AN EXPLORATORY DESCRIPTIVE STUDY OF THE HIV/AIDS KNOWLEDGE, SEXUAL BEHAVIOR AND CONDOM USE AMONG AFRICAN-AMERICAN COLLEGE STUDENTS

A THESIS

SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTERS OF SOCIAL WORK

BY

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ATLANTA, GEORGIA

DECEMBER, 1996

ABSTRACT

SOCIAL WORK

ROBINSON, EVA B.A., CENTRAL STATE UNIVERSITY, 1991

AN EXPLORATORY DESCRIPTIVE STUDY OF THE HIV/AIDS KNOWLEDGE, SEXUAL BEHAVIOR AND CONDOM USE AMONG AFRICAN-AMERICAN COLLEGE STUDENTS

Advisor: Professor Hattie M. Mitchell

Thesis dated: December, 1996

The purpose of this study was to assess and describe the level of awareness about HIV/AIDS knowledge, sexual behavior and condom use among African-American college students. A total of thirty African-American male and female college students enrolled in the Atlanta University Center were asked to participate in this study. There were twenty-nine college students who agreed to participate in the study. Simple descriptive statistics and t-test were used to analyze the data.

The findings of this study accepted the hypothesis that there was no significant statistical difference between HIV/AIDS knowledge, sexual behavior and condom use among African-American college students.

ACKNOWLEDGEMENTS

I would like to first give thanks to God for my journey thus far. Thank you Lord for the plans that you have for me that are much bigger than my own. None of this would be possible.

I would like to specifically acknowledge the following persons: To my mother, Ms. Diane Robinson, thank you for all of the many gifts of life you have given to me. I will forever be grateful. To my father, Mr. Louis Robinson and my extended family. To my siblings, Marie and Darnell Robinson, may your dreams lead you to happiness and good health. To my "Bigmama", Mary Matthews, thank you for your love and support. To all of my aunts, uncles, cousins, nieces, nephews and friends, thank you all for believing in me. I will always love you. To Mrs. Eva Mae Dozier, my maternal great grandmother, thank you for teaching me how to pray. May my life be an example of your gifts to our family. With all my love. Your Namesake.

I would like to give additional thanks to: Professor Hattie M. Mitchell for your patience, guidance, assistance and care while aiding me in the completion of my thesis; to Dr. Anne Fields-Ford, thank you for your support. To the faculty and staff of Clark Atlanta University, thank you all. I love you all. Last but not least, I would like to give thanks to Dr. Rosa Ashe. You have truly been a blessing to my life. I will never forget you.

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CHAPTER ONE

INTRODUCTION

In multiple, fragmentary and often contradictory ways social workers struggle to achieve some sort of understanding of "HIV/AIDS Knowledge, Sexual Behavior, and Condom Use Among African-American College Students." This exploratory descriptive study seeks to examine the relationship between HIV/AIDS knowledge, sexual behavior and condom use among a sample of African-American male and female college students.

HIV/AIDS was first recognized in homosexual men and intravenous drug abusers, cases of AIDS have been accelerating. Drug users who inject are among those persons considered at high-risk for HIV/AIDS. HIV/AIDS is a real disease syndrome, damaging and killing real human beings. HIV/AIDS high mortality rate, now accounts for one in every three deaths among African-American women 25 to 44 years old.[1] HIV-related illnesses and death have the greatest impact on young adults, particularly racial and ethnic minorities.

Since the HIV/AIDS epidemic began in the 1980s, over 500,000 Americans have been reported with AIDS. At least 300,000 of these people have died of the HIV-related

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[1]Centers for Disease Control, HIV/AIDS Surveillance Report (Atlanta: Centers for Disease Control, 1993), 1-22.

illnesses.[2] Most significantly, African-Americans are disproportionately affected in every way you look at the epidemic.

Various observers have noted that HIV/AIDS pandemic will be beyond control by the year 2000. It is crucial for social workers to examine key high risk variables that are disproportionately impacting heterosexual African-American college students. Many African-American college students believe they can take high risks and nothing negative will happen.

In recent years, HIV/AIDS cases among 13-19 year olds and young adults in their twenties continue to rise. It is estimated that one of every 500 college students was infected with HIV. Epidemiologic analyses indicate that college students and sexual behavior are not changing despite awareness of risks associated with the transmission of HIV/AIDS, and other sexually transmitted diseases.[3] Yet, there has been very little empirical published social work research on HIV/AIDS and sexual behavior among heterosexual African-American college students.

Over the last decade, much has been written about HIV/AIDS. However, there are no clinical social work

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[2]Laurie Garrett, The Coming Plague: Newly Emerging Disease in a World Out of Balance (New York: Penguin Books, 1995), 403-409.

[3]J. M. Reinish and C. A. Hill, "Sexual Behavior Among Heterosexual College Students," Focus (March 1990): 17-21.

literature and research materials published addressing issues concerning the attitudes and safe sex behaviors among African-American college students that social work professionals could use as references to their practice. Is social work prepared to respond to the needs of this population? At present, the answer, despite the best efforts of many professional social workers seems to be no.

Given the predictions of dramatic increases in the number of African-American teens and adolescents with HIV/AIDS, the question is, What are the roles of the various components of our society in response to this complex situation? Social workers have a pivotal and expanding role in responding to the AIDS epidemic in general, and African-American college students in particular.

The growing epidemic of HIV/AIDS infection and AIDS among African-American college students has highlighted the importance of social workers developing effective service delivery programs. Approximately 80% of adolescents, age 13 to 21 years, with AIDS were infected through sexual exposure or intravenous drug use.[4] These kinds of exploratory behavior put this age group (13 to 21 years) at risk for other problems including sexual transmitted disease,

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[4]S. V. Vermund, K. Hein, H. Gayle, J. Carey, P. Thomas, and E. Drucker, "AIDS Among Adolescents in NYC: Case Surveillance Profiles Compared With the Rest of the U.S.," American Journal Disease Child 143 (1989): 1220-1225.

unwanted pregnancy, and drug addiction. AIDS is still the sixth leading cause of death among people aged 13 to 24.

The magnitude of the epidemic in general, coupled with its projected growth, necessitates that social workers be well informed about risks associated with the transmission of HIV/AIDS among heterosexual African-American college students. The American Association of World Health note that heterosexual contact accounted for only five percent of reported AIDS cases among male adults/adolescents in 1995. Heterosexual contact accounted for 38% of reported AIDS cases among female adults/adolescents in 1995.[5]

The central issue for social workers in working with African-American college students at risk is the prevention of infection by high-risk related behaviors. In a survey of knowledge and reported risk behaviors among African-American college students it was noted that: 64% of the females participated in anal intercourse; 45% of the males had been treated for a STD; 34% of males told a lie in order to have sex; 32% of the males and 23% of the females were involved with more than one sexual partner; and 55% of the sexually active students responding to the survey said they did not use condoms.[6] Social workers must understand that the

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[5]American Association for World Health, World AIDS Day: One World, One Hope (Washington, D.C.: American Association for World Health, 1996), 10.

[6]M. Kuntz-Ishii, "AIDS and Sexual Behavior Changes in a College Student Sample," Sociology and Social Research 25 (1988): 181-186.

issues of personal and behavioral characteristics provide critical elements of the mix regarding high risk behaviors.

It appears that many sexually active college students have the knowledge about the transmission of HIV/AIDS, but to some degree lack an understanding of focused, partner-specific discussion and skills needed for risk reduction.[7] Knowledge and awareness of HIV/AIDS has not translated into major changes in sexual behaviors among African-American college students. For this reason, more focused social work education needs to be directed towards this population.

Presuming no cure is found in the near future, HIV/AIDS will become a disease of devastating proportions with adverse effects not only on those African-American college students at risk, but indirectly on all society. It is clearly a health care issue for the rest of the century. It will force an examination and reexamination of a number of issues important to the social work profession.

A recent CDC report estimates that there are between 25,000 to 35,000 cases of HIV infected college students in the United States.[8] It is predicted that AIDS will soon be the leading cause of death among college students. There is

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[7]J. D. Baldwin and J. I. Baldwin, "Factors Affecting AIDS-Related Sexual Risk-Taking Behavior Among College Students," Journal of Sex Research 25 (1988): 181-186.

[8]Centers for Disease Control, "Revision of the CDC Surveillance AIDS Report: Supplement," Morbidity and Mortality Weekly 36 (August 1986): 35-155.

an urgent need for social work practitioners to develop knowledge, skills in communicating about the interactive relational and cultural environment that influence the probability of condom use, and enhance overall relational satisfaction.

The incidence of HIV/AIDS among African-Americans poses serious threats to the survival and future of African-Americans. Social workers must become increasingly aware of sociocultural factors influence on human growth and development. Social class, education, race, ethnicity, sex and place of residence strongly influence the life cycle of the college student. These are key concepts for social workers to come to appreciate.

HIV/AIDS has been emotionally and politically charged issue since its identification in the 1980s. HIV/AIDS is frightening and debilitating. Many social workers make a conscious decision to work with this population out of a sense of responsibility. There are clearly other social workers who have been placed in the epidemic reluctantly, perhaps out of a need for some job security, but lacking a primary sense of compassion for this population. This study recognizes the need for social workers with this population and helps them to learn powerful problem-solving techniques.

Statement of the Problem

The problem presented to social workers regarding the relationship HIV/AIDS knowledge, sexual behavior, and condom

use among African-American college students vary in severity and duration. HIV/AIDS is a growing phenomenon among some African-American college students. The problems range from psychological distortions to the lethality of the condition and in some cases, significant guilt and shame. Social workers are being faced with problems associated HIV/AIDS among African-American college students with little guidance from empirical social work research, literature, assessment and intervention guidelines for this population. An accurate assessment is vital to tailor the treatment intervention level for high risk behaviors.

As psychosocial problems associated with HIV/AIDS among African-American college students become increasingly evident, more empirical social work research will be needed. If psychosocial pathology is discovered among African-American college students with HIV/AIDS, then psychosocial social work methods for intervention must be developed. The social work literature offers little information on psychosocial interventions for HIV/AIDS among African-American college students. As a result, social workers might feel unprepared and uninformed about effective assessments and interventions. Empirical research, clinical guidelines are needed for those who work with this problem.

Since the spread of HIV/AIDS involves some elements of behavior over which African-American college students have at least some control and choice. HIV/AIDS will

involve a greater societal and health focus on disorders involving risk-taking, impulse control, compulsivity and hedonism; this includes alcohol and drug taking behaviors. Such a focus for social workers will be stimulated by many forces.

Social workers must broaden their perspective to consider not only the multiple ways in which this population functions, but also external factors that have an impact on them. For example, the role of alcohol and drugs in the HIV/AIDS epidemic is a problem that social workers cannot avoid assessing. Alcohol and drugs give its users a sense of invincibility, playing an increasing role in the HIV/AIDS epidemic. Changing attitudes and behaviors which reduces greater risk taking for HIV/AIDS, and responding to episodes of HIV/AIDS, and modifying the behavior of those African-American college students at high risk are each essential to a comprehensive strategy to reduce high-risk behaviors.

The rapid increase in the number of drugs and HIV/AIDS has serious consequences for health and social work providers. According to CDC, I.V. drug use is implicated in 71% of AIDS cases among women.[9] The lack of integrated information about this population presents a grave problem in early intervention, satisfactory measures of the extent

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[9]Centers for Disease Control, "HIV/AIDS Surveillance Report," Morbidity and Mortality Weekly 37 (1993): 377-382.

and impact of drugs and HIV/AIDS among African-American college students, owing to the difficulties in measuring private activity. There is not question, however, that the problem is great.

HIV/AIDS is presently an incurable, fatal disease, so that the only means of eliminating it lies in prevention. Prevention requires education, safer practices in sexual and I.V. drug behaviors, or non-risk behavior relationships. The HIV/AIDS problem has the potential to resurrect some of the old conflicts in the chemical dependency field. It is imperative that social workers not let this problem fragment professional service delivery. Nevertheless, education remains our best defense against misplaced fears and further spread of HIV/AIDS.

Purpose/Significance of the Study

Concrete thinking and perceptions of invulnerability may limit persons aged 13 to 21 years, may limit this age group understanding of the future consequences of risky behavior. This age group, therefore require very specific and practical information to help them understand their risk and how to change their behavior.

The purpose and thrust of this study has been to explore HIV/AIDS knowledge, sexual behavior, and condom use among African-American college students, and to identify central social work considerations that are part of the delivery of treatment services. Social workers must

recognize the importance of developmental process and the implications this poses with respect to this population.

Clearly, there is a need for some further empirical examination by social workers to obtain an appropriate perspective on HIV/AIDS knowledge, sexual behavior, and condom use among African-American college students. Each African-American college student is a unique individual who is the sum total of his/her life experiences. Concurrently, he/she interacts with and is acted upon by social, economic and political forces in his/her environment. For example, HIV/AIDS can be transmitted by all three forms of intercourse: vaginal, anal, and oral, regardless of the sex of the partner.[10] These variables seem to occur most consistently in relation to African-American college students problem behavior are stress, skill deficiencies and situational constraints. Social workers must consider the magnitude of this issue for the African-American community.

The purpose of this study is to provide an understanding of the present state of knowledge about HIV/AIDS knowledge, sexual behaviors and condom use among a sample of African-American college students and to identify issues which social workers will have to deal with in the coming decade. African-Americans are differently affected by HIV/AIDS, so that social workers will need to consider

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[10]Center for Population Options, AIDS and Adolescents (New York: Center for Population Options, 1987).

the specific needs of African-American college students in their work.

Given the increases in African-American college students HIV/AIDS status indicate a significant need for empirical social work research. Knowledge, attitudes about HIV/AIDS, alcohol and other drugs, decision-making skills, and self-esteem appear to have limited influence on the drinking and drug using behavior, sexual behavior of college students. The number of HIV/AIDS affected African-American college students is more certain, and the adverse consequences of exposure to HIV better known. HIV/AIDS is disproportionately a disease of color. African-Americans in all their diversity, whether in urban, suburban lifestyles, share characteristics placing them in higher HIV/AIDS risk group. It is significant for social workers to understand that as a group African-American college students are more vulnerable to alcohol- and drug-related complications when they do use drugs and drink. Services to this population should be culturally appropriate, accessible, and comprehensive. For college students affected by drugs, alcohol, or HIV/AIDS, successful outreach is enhanced significantly when social workers address their particular concerns.

Social workers must appreciate the fact that the physical and psychosocial health of African-American college students are inextricably interwoven. This study will

provide significant descriptive data on this population and respond to the demands for social workers to enhance their knowledge base, skills and intervention strategies for treatment of this growing population. It is imperative for African-American college students to avoid behaviors that place them at risk.

CHAPTER TWO

LITERATURE REVIEW

This brief literature review will address HIV/AIDS knowledge, sexual behavior, and condom use among African-American college students.

HIV/AIDS Knowledge

In the early years of the HIV/AIDS epidemic, African-American college students received less attention than younger children and adults. This was due at least in part to the fact that most of the early knowledge about the AIDS epidemic was initially identified primarily among homosexual and bisexual men, hemophiliacs, and intravenous drug users in large urban areas.[1]

It is important for social workers to take a closer look at this tragic disease among African-American college students. A study of second year Master of Social Work (MSW) students at the University of California-Berkeley revealed that gaps in AIDS knowledge exist among students, even though the school is located in a major AIDS epicenter.[2] HIV disease is a serious threat to social and

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[1]Yolanda E. Diaz and Jeffery A. Kelly, "AIDS Related Training in U.S. Schools of Social Work," Journal of the National Association of Social Workers 36 (January 1991): 1-96.

[2]S. Wexler, "Social Welfare Students and AIDS: A Survey of Knowledge, Attitudes, and Professional Preparation," Journal of Teaching in Social Work 3 (1989): 131-149.

economic development, particularly in developing African-American college students, because it affects the students at the height of their productivity and deprives the African-American communities of potential leaders and skills.

Another study of students (75% of them social work students) at the University of Kentucky indicated that greater knowledge of HIV infection is associated with greater empathy for people with AIDS and with a lower degree of fear of AIDS.[3] Only as social workers become knowledgeable about the range and impact of this disease among African-American college students will they be able to affect provision of care/services, educate their clients, colleagues, and communities effectively.

The limited data available suggest that African-American college students are not sufficiently informed about the cause, transmission, and especially the prevention of HIV infection. Thus, a large proportion of African-American college students may not take appropriate preventive measures to reduce risk of HIV infection. According to Di Clemente, Boyer, and Morales, minority adolescents, in comparison to their white counterparts, are less knowledgeable at AIDS overall, and are particularly

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[3]Ibid.

ill-informed about the effectiveness of condoms as a protective barrier against infection.[4]

Although adolescents and college students are at risk of becoming infected with and transmitting HIV, many of them are misinformed about their risk of transmission. The need for AIDS education and risk reduction counseling for adolescents has been widely documented, multidimensional studies found that none of the social workers surveyed professed such a need.[5] Even when early attempts were made to educate the public about AIDS, fear and misinformation was widespread.

Most alarming, despite the rapid increases in new cases of HIV among women and children, men, especially

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[4]R. J. Di Clemente, C. B. Boyer, and E. Morales, "Minorities and AIDS: Knowledge, Attitudes, and Misconceptions Among Black and Latino Adolescents," American Journal of Public Health 1 (1988): 5-57.

[5]D. D. Royce, S. S. Dhooper, and L. R. Hatch, "Undergraduate and Graduate Students' Attitudes Towards AIDS," Psychological Reports 60, no. 11 (1987): 859-860; J. Gunn-Brooks, C. B. Boyer, and K. Heim, "Preventing HIV Infection and AIDS in Children and Adolescents," American Psychologist 43 (1988): 958-964; K. Davis, P. Fitzgerald, and A. Garret, AIDS Education Study: Assessment of Knowledge and Attitudes Among Junior High and High School Students (New Haven: Yale School of Medicine, Department of Epidemiology and Public Health, 1986); Y. E. Diaz, "AIDS Related Knowledge, Attitudes and Behaviors Among Adolescents with a History of Involvement with the Youth Court System in Mississippi" (M.A. thesis, University of Southern Mississippi, 1989); R. J. Di Clemente, J. Zorn, and L. Temoshok, "Adolescents and AIDS: A Survey of Knowledge, Beliefs, and Attitudes About AIDS in San Francisco," American Journal of Public Health 76 (1986): 1443-1445; J. A. Flora and C. E. Thoreson, "Reducing the Risk of AIDS in Adolescents," American Psychologists 43 (1988): 965-970.

people of color, remain at the focus of the epidemic. As of 1995, 55% of the cumulative AIDS cases in the U.S. were racial/ethnic minorities among males, over 77% among adolescent/adult females and 85% among children. AIDS rates are highest among African-Americans (92.6) was 6 times greater than among whites (15.4) and 2 times greater than among Hispanics (46.2).[6]

HIV infection through sexual contact now constitutes an increasing percentage of reported cases in adolescents and young adults. Many young people are imbedded in social contexts where the HIV risking behaviors to be prevented may be culturally and subculturally normative, highly reinforcing, and not easily modified. Adolescent invulnerability beliefs present significant barriers to the adoption of preventive behavior among this population, despite knowledge about AIDS.[7] Studies indicate that information on adolescents' HIV-related knowledge, attitudes, beliefs, and behaviors is available.

Becker and Joseph reviewed the current literature concerning knowledge possessed by homosexual and bisexual men, intravenous drug users, and adolescents about HIV infection and concluded that "homosexual-bisexual men are

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[6]Centers for Disease Control, HIV/AIDS Surveillance Report (Atlanta: Centers for Disease Control, 1993).

[7]K. Heim, "AIDS in Adolescents: A Rationale for Concern," New York State Journal of Medicine 87 (1981): 290-295.

the best informed and the most likely to change their behavior, while the opposite is true of late adolescent and young adult heterosexuals."[8] For example, most adolescents knew that sexual intercourse and sharing needles for I.V. drug use are the main modes of HIV transmission. They were somewhat more likely to associate HIV transmission with homosexual as opposed to heterosexual contact. The most common misconceptions were about acquisition of HIV through casual contact and blood donation and believing that one could tell if a person was infected with HIV. Even with adequate knowledge, many adolescents fail to translate this knowledge into appropriate behavior.[9]

Knowledge related to AIDS and HIV infection in adolescents has grown rapidly. Minority youths are at greater risk for HIV infection than their white peers! Fifty-one percent of adolescent AIDS cases are minority. AIDS is still the sixth leading cause of death among people aged 15 to 24.[10] Further information is needed about the clinical, epidemiologic, behavioral, and prevention aspects of HIV infection among minority youth.

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[8]M. H. Becker and J. G. Joseph, "AIDS and Behavioral Change to Reduce Risk: A Review," American Journal of Public Health 4 (1988): 394-410.

[9]L. R. Jaffe, M. Seehaus, C. Wagner, and B. J. Leadbeater, "Anal Intercourse and Knowledge of Acquired Immunodeficiency Syndrome Among Minority Group Female Adolescents," Journal of Pediatric 112 (1988): 1005-1007.

[10]Centers for Disease Control, HIV/AIDS Surveillance Report, 1-22.

Targeting African-American college students whose behavior places them at high risk of HIV infection is essential for social workers. A report in the American Association for World Health, revealed that in 1995, AIDS was the leading cause of death among men aged 25 to 44; AIDS is the third leading cause of death among women aged 25 to 44; there were 405 reported AIDS cases among "adolescents" age 20 to 24.[11] Recently, the adolescent and young adult population has been identified as a group potentially at high risk for AIDS because of its sexual activity and experimentation with drugs.

Additional data on the antecedents of high-risk behavior among adolescents and young adults are critically needed to prevent these kinds of behaviors from developing. Some researchers have found in studies published in 1994 and 1995 in New York, Pittsburgh and San Francisco, nine percent, seven percent, and nine percent, respectively, of males who have sex with males age 13 to 25 were HIV-positive. These rates are more than 20 times greater than the estimated rate among the overall population.[12]

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[11]American Association for World Health, World AIDS Day: One World, One Hope (Washington, D.C.: American Association for World Health, 1996), 10-11.

[12]Larry M. Gant, "HIV/AIDS," in Encyclopedia of Social Work, 19th ed., vol. 2, eds. Jacqueline M. Atkinson and Kenneth R. Greenhal (Maryland: National Association of Social Workers, 1995), 1306-1313.

The HIV/AIDS epidemic has affected everyone throughout the nation, but young people, in particular, are increasingly at risk for HIV/AIDS. Since the median incubation period between HIV infection and AIDS diagnosis is about 10 years, it is clear that many people who were diagnosed with AIDS in their 20s became infected as teenagers. What is more alarming is that adolescents have not significantly changed sexual practice nor methods of contraception as a result of the AIDS epidemic.[13]

HIV infection and AIDS present many special concerns for adolescents and young college students in the areas of modes of transmission, unsafe sexual practices, shared needle use. Many believed AIDS was a male homosexual problem that did not concern them because they had sexual relations with heterosexual men only. A survey study found three factors influencing their high risk behaviors, i.e., socioeconomic indicator, sexual activity, and level of knowledge about AIDS. All of the respondents engaged in anal sex, one-third practiced oral sex, and none mentioned mutual masturbation as a possible alternative to sexual relations. When questioned about their knowledge of AIDS and its transmission routes, 83 percent replied that AIDS was transmitted sexually, 9 percent replied that AIDS was

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[13]L. Struin and R. Huthchinson, "Acquired Immunodeficiency Syndrome and Adolescents: Knowledge, Beliefs, Attitudes, and Behaviors," Pediatrics 83 (1986): 825-828.

transmitted through blood and blood products. No one knew that AIDS could be transmitted perinatally. Eight percent did not know anything at all. When asked about prevention techniques, 50 percent replied that AIDS could be prevented by using a condom, 8 percent replied that AIDS could be prevented by using a condom and avoiding sharing needles, 7 percent replied that AIDS could be prevented by using a condom and having relations with only one partner, 8 percent replied that AIDS could be prevented by avoiding exchange of blood or semen, 8 percent did not know.[14]

To understand better the factors related to college students' knowledge of HIV/AIDS, Fisher found that if minority youth consider themselves to be at little risk, they will be unlikely to adopt precautionary behavior.[15] However, educational programs increase knowledge about the likelihood of contracting the virus and may elevate anxiety, but they have not led youth to adopt precautionary behavior.[16]

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[14]Lydia S. Bond, Ed.D., Rafael Mazin, M.D., and Maria Victoria Jiminez, B.A., "Street Youths and AIDS: Special Supplement to AIDS Education and Prevention: HIV and Street Youth," International Society for AIDS Education (1992): 14-42.

[15]J. D. Fisher, "Possible Effects of Reference-Group Based Social Influence on AIDS Risk Behavior and AIDS Prevention," American Psychologist 43 (1988): 914-920.

[16]J. I. Baldwin, S. Whitley, and J. D. Baldwin, "Changing AIDS and Fertility-Related Behavior: The Effectiveness of AIDS and Fertility-Related Behavior: The Effectiveness of AIDS Education," Journal of Sex Research 27 (1990): 245-262.

Few studies are available targeting African-American college students. As a result, as social work practitioners, our understanding of the factors implicated in risk taking, measures for the conduct of reliable and valid assessments, and of intervention methods sensitive to gender and ethnic differences among college students is limited.[17]

In a study of 299 women regarding "AIDS and women knowledge, perceived risk, and behavioral correlates in rural and urban communities in South Carolina, found that there was a discrepancy between their knowledge and their reported sexual behavior."[18]

In a study of university students' attitudes, knowledge and behaviors related to AIDS, the findings indicate that the subjects expressed positive attitudes towards persons with AIDS, demonstrated a moderate level of knowledge about AIDS, and reported engaging in some risky sexual behaviors. The findings suggest that greater

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[17]Abbas Tashakkori and Valda D. Thompson, "Predictors of Intention to Take Precautions Against AIDS Among Black College Students," Journal of Applied Social Psychology 22 (1992): 736-756.

[18]Quasir Mukhirtar, Ph.D., "AIDS and Women Knowledge, Perceived Risk and Behavioral Correlates in Rural and Urban Communities in South Carolina," Dissertations Abstracts International 51, no. 5 (November 1990): 285.

knowledge about AIDS is not associated with lower levels of sexual risk.[19]

The average age for sexual experience among U.S. adolescents is 16 and approximately three-fourths of high school students have had sexual intercourse by the twelfth grade.[20] The AIDS-positive adolescent, like all adolescents and people in general, needs love, affection, and good relationships with his or her peers. An HIV diagnosis can damage an adolescent's already fragile self-esteem. Oxtoby found that many adolescent women with HIV express considerable concern about their ability to become pregnant and to have healthy babies. Current statistics in the U.S. indicate that 25 to 30 percent of babies born to HIV-positive mothers will themselves be HIV positive.[21]

Sexual Behavior

The population most affected by AIDS in the United States continues to be men who have sex with men (42% of all

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[19]Rosemary B. Hughes, Ph.D., "University Students Attitudes, Knowledge and Behaviors Related to AIDS," Dissertation Abstracts International 51, no. 2 (August 1990): 179.

[20]John O. Woodruff, Diane Doherty, and Jean Garrison Athey, Troubled Adolescents and HIV Infection: Issues in Prevention and Treatment (Washington, DC: CASSP Technical Assistance Center, Georgetown University Child Development Center, 1989), 6-7.

[21]M. Oxtoby, "Perinatally Acquired Human Immunodeficiency Virus Infection," Pediatrics Infectious Disease Journal 9 (1990): 609-619.

new AIDS cases in 1995). Among men ages 20-24, male-to-male sexual contact and/or injecting drug use accounted for 76 percent of AIDS cases and 63 percent of HIV infection cases reported in 1995. Heterosexual contact accounted for 38 percent of reported AIDS cases among female adults/ adolescents in 1995. Sexual assault and domestic violence can put women at risk for HIV infection. Every year approximately three million American teenagers contract a sexually transmitted disease.[22]

Many aspects of the lifestyle of adolescents and young adults, seem to place them directly in the path of the AIDS epidemic. Recent studies have shown that self-administered methods of asking sensitive questions about sexual behavior may yield less lucid than responses face-to-face interviews.[23] Adolescence is a time when sexual behavior and drug use patterns are developing; clearly it is a critical time to have an impact on those behavior patterns. However, information about African-American college students is still limited.

Data from AIDS cases reports and selected seroprevalence surveys indicate that behavior is a major factor for placing African-Americans at risk for HIV

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[22]American Association for World Health, World AIDS Day: One World, One Hope (Washington, D.C.: American Association for World Health, 1996), 9-11.

[23]G. J. Remafidi, "Adolescent Homosexuality: Psychosocial and Medical Implications," Pediatrics 79 (1987): 331-337.

infection. Studies indicate that many adolescents may be at risk for HIV infection through sexual exposure.[24] There has been two to three decades with both a declining age at first intercourse and increasing number of partners over time. The majority of adolescents (80% of males and 70% of females) initiate sexual intercourse by age 20.[25] It is suggested that half of these teenagers engage in unprotected sex during their first intercourse.

In some studies of urban adolescents the age at first intercourse is as young as 12 years.[26] Eighty percent of pregnancies among adolescents are unintended, underscoring the extent of intercourse without effective contraception. Acquisition of an STD may also serve as a marker for the kinds of sexual behavior that are associated with the spread of HIV. One in seven adolescents aged 15 to 19 gets an STD each year.[27]

There are subgroups of adolescents who are at higher risk of HIV infection than others. Male adolescents who have intercourse with other males are at particular risk for

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[24]K. R. O'Rielly and S. O. Aral, "Adolescence and Sexual Behavior," Adolescent Healthcare 6 (1985): 262-270.

[25]L. Jaffi, M. Seehaus, M. Wagner, and Leadbetter, "Anal Intercourse and Knowledge of AIDS Among Minority-Group Adolescents," Journal Pediatric 112 (1988): 1005-1007.

[26]K. Heim, M. I. Cohen, and A. Marks, "Age at First Intercourse Among Homeless Adolescent Females," Journal Pediatrics 93 (1978): 147-148.

[27]E. W. Hook, "Syphilis and HIV Infection," Journal Infectious Disease 160 (1989): 530-534.

HIV given the high prevalence of HIV infection among gay and bisexual adult men. Between 17 and 35 percent of young males have had same-sex experiences to orgasm. Not all adolescents who engage in same-sex intercourse identify themselves as gay or bisexual, their first partner is on average 7 years older.[28]

Adolescents who engage in the exchange of sex for money, drugs, food, or "survival sex" are at particularly high risk for HIV infection. There are an estimated 900,000 teenagers who engage in some form of survival sex or "sex work," of whom two-thirds are female. There are approximately 250,000 homeless teenagers.[29] Many of these adolescents also survive on the streets by engaging in high-risk sexual behavior in exchange for food, shelter, protection, and companionship.

Sexual abuse poses yet another risk for HIV transmission. Of reported sexual abuse cases, 17 to 30 percent of the victims are in the adolescent age group. In addition to direct risk from an HIV-infected abuser, sexual

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[28]R. E. Sorenson, Adolescent Sexuality in Contemporary America (New York: World Publishing, 1973), 21.

[29]P. A. Paraski, "Health Care Delivery and the Concerns of Gay and Lesbian Adolescents," Journal Adolescent Healthcare 8 (1987): 188-192.

abuse puts adolescents at risk by increasing the likelihood of future high-risk behavior.[30]

Drug use also puts adolescents at risk for HIV infection. The link between intravenous drug use, needle sharing, and AIDS was established within the first years of the reported epidemic. In 1988, the Monitoring the Future longitudinal study released data showing that approximately eight percent of high school seniors reported using cocaine in the previous year. The peak age of initiation of cocaine use was 15 to 16 years.[31]

Crack use appears to be highly associated with risk-related sexual behavior. Crack use has recently been found to be associated with HIV infection among adolescents seen at a HIV clinic in New York City reported heavy crack use and denied intravenous drug use.[32] Despite a good knowledge base about safe sex, only one of nine males who were having sexual intercourse consistently practiced safer sex.

According to Simon and Jagnon, sexual behavior is influenced by three factors: the cultural, the

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[30]P. A. Harrison, N. G. Hoffman, and G. E. Edwall, "Differential Drug Use Patterns Among Sexually Abused Adolescent Girls in Treatment for Chemical Dependency," International Journal of Addiction 24 (1989): 499-514.

[31]J. Garison, ed., "AIDS and Adolescents: Exploring the Challenge," Journal Adolescent Healthcare 10 (1989): 1-69.

[32]T. Bell and K. Heim, "The Adolescent and Sexually Transmitted Diseases," in Sexually Transmitted Diseases, ed. K. Holmes (New York: McGraw-Hill, 1984), 73-84.

interpersonal, and the intrapsychic.[33] These factors enable a person to link individual sexual desires, arousal, eroticism, and fantasy to social meaning. Evidence of the lack of specificity for safer sex episodes was explored by Edgar and Fitzpatrick. Participants were asked to describe an "evening that would lead to and include sexual intercourse." No respondent spontaneously mentioned asking a partner any of the questions related to risk factors and condom use before having intercourse.[34]

In the study of "nonmonogamous-heterosexual women's perception of their risk of AIDS as associated with their sexual behavior," it was found that there was no significant difference between the two groups in their perception of the riskiness in the sexual behavior.[35] In a study of 30 African-American males sexual behaviors and the risk of HIV infection, found that most of the men in the study had misconceptions about transmission of HIV and many believed

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[33]W. Simon and J. H. Jagnon, "A Sexual Scripts Approach," in Theories of Human Sexuality, eds. J. H. Greer and W. O'Donohue (New York: Plenum Press, 1987), 363-383.

[34]T. Edgar and M. A. Fitzpatrick, "Memory Structures for Sexual Interaction: A Cognitive Test of the Sequencing of Sexual Communication Behaviors," Southern Speech Communication Journal 53 (1991): 385-405.

[35]Susan M. Jordan, Ph.D., "Nonmonogamous Heterosexual Women's Perception of AIDS as Associated with Their Sexual Behavior," Dissertation Abstracts International 51, no. 5 (November 1990): 209.

that their sexual behavior did not place them at risk for HIV.[36]

Sexual contact is without doubt the most common means of infection. A survey of community college students found that heterosexuals currently practicing safer sex identified greater benefits and fewer barriers to practicing safer sex, evidenced higher levels of perceived efficacy and held a more internal focus on control than did sexually active heterosexuals not currently practicing safer sex.[37]

Condom Use

Condoms are the only form of protection against both pregnancy and sexually transmitted diseases (STDs), including HIV. Widely varying rates of condom use are reported. In a national survey of adolescent males in 1988, 58% of 17 to 19 year olds reported condom use at last intercourse, but these rates were significantly lower among males who had five or more sexual partners, had paid for

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[36]Jerome Wright Wendell, MSW, "African-American Male Sexual Behaviors and the Role for HIV Infection: Social Work Implications," Masters Abstracts International 33, no. 3 (1990): 211-212.

[37]Amy Cathrine Willis, Ph.D., "The Relationship of Health Belief Model Variables Perceived Self-Efficacy, Internal-External Locus of Control, and Knowledge About AIDS to the Practice of Safer Sex: A Survey of Community College Students," Dissertation Abstracts International 51, no. 6 (December 1990): 79-80.

sex, or had used drugs intravenously.[38] In a survey conducted among middle class, urban adolescents at a health clinic in 1985 and 1986, only two percent of females and eight percent of males reported using condoms every time they had intercourse.[39] In another survey of urban, minority, adolescent females at a health clinic, 26 percent reported engaging in anal intercourse, but condoms were used in only one-third of these encounters.[40]

Given this data it is important for social workers to obtain a detailed history of the sexual risk behaviors of African-American college students. A study of runaway, predominantly minority males found that most (84%) were sexually active with female partners used a condom at least once, but fewer (43%) of those who were sexually active with males ever used a condom. Consistent condom use was reported by 13 percent of the youth. Far fewer youths reported using condoms in every encounter.[41]

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[38]F. L. Sonenstein, J. H. Pleck, and L. C. Ku, "Sexual Activity, Condom Use an AIDS Awareness Among Adolescent Males," Family Planning Perspective 21 (1989): 152-158.

[39]S. M. Kegeles, N. E. Adler, and C. E. Irwin, "Sexually Active Adolescents and Condoms: Changes Over One Year in Knowledge, Attitudes and Condom Use," American Journal Public Health 78 (1988): 460-461.

[40]T. C. Quinn, D. Glasser, and R. O. Cannon, "Human Immunodeficiency Virus Infection Among Patients Attending Clinics for Sexually Transmitted Diseases," New England Journal Medicine 318 (1988): 197-203.

[41]J. A. Flora and C. E. Thorensen, "Reducing the Risk of AIDS in Adolescents," American Psychologist 43 (1988): 965-970.

The risk of infection through sexual intercourse can be reduced (but not eliminated) by practicing what has been called "safer sex". This involves the use of a barrier protection such as latex condoms, they cannot be used by a female without the consent of her partner. When a woman is unable to negotiate latex condom use with her partner and thus protect herself from infection, she becomes vulnerable to infection. This affects the very fabric of families and communities.[42]

Personal, religious and cultural biases about condoms are major obstacles to their use even when they are available and affordable. Teaching people how to use condoms consistently and properly is an educational task for social workers involved in HIV-related practice. Additional research has been directed towards the female condom. Reality was recommended by CDC as a means of preventing STDs, including HIV/AIDS. It is the only disposable barrier device designed for women that is comfortable and easy to use. The female condom is most beneficial for women whose sex partners do not use latex male condoms. Made of a polyurethane sheath, the condom is unlikely to rip or tear,

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[42]Gary A. Lloyd, "HIV/AIDS Overview," in Encyclopedia of Social Work, 19th ed., vol. 2, eds. Jacqueline M. Atkinson and Kenneth R. Greenhal (Maryland: National Association of Social Workers, 1995), 1325-1330.

comes prelubricated and is meant to be used for only one sex act.[43]

Women have been given the responsibility of practicing safer sex within sociocultural context that defies this possibility and may in part explain the infrequent use of condoms among high-risk groups. "Risk-taking" implies autonomy in the world. It might be more accurate to characterize women's sexual relationships in terms of power. In fact, given the power differentials in contemporary society it may be sensible to think of HIV in poor women of color as vertical transmission instead of horizontal transmission.[44]

Large surveys of minority youth suggests that sexual activity is initiated at an early age, that protective measures such as condoms are not consistently used, and that use of protective measures may decline with age.[45] Any behavior or practice that helps the virus enter the bloodstream must be considered risky.

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[43]K. Jean Peterson, "HIV/AIDS: Women," in Encyclopedia of Social Work, 19th ed., vol. 2, eds. Jacqueline M. Atkinson and Kenneth R. Greenhal (Maryland: National Association of Social Workers, 1995), 1325-1330.

[44]M. C. Ward, "A Different Disease: HIV/AIDS and Health Care for Women in Poverty," Culture, Medicine and Psychiatry 17 (1993): 411-430.

[45]F. L. Sonestien, J. H. Pleck, and L. C. Ku, "Sexual Activity, Condom Use and AIDS Awareness Among Adolescent Males," Family Planning Persect 21 (1989): 152-158.

Friemouth and associates[46] surveyed 204 college students who had a new sexual partner within the 12 month period prior to the data collection, asking them to focus on their most recent experiences of having sex for the first time with a new partner. Cantania, Coates, Greenblatt, and Miller[47] investigated the relationship between communication and condom use by surveying 114 female adolescents attending a family planning clinic in California. Ross[48] suggested that condom use is associated with communication skills. The more individuals were perceived to be ineffective communicators, the more likely they were to engage in sex without protection.

Cvetkocvich and Grote compared the communication abilities of users and non-users of contraception; they interviewed 87 sexually active high school students, they found that subjects who tended to use condoms not only had higher communication abilities than those who used no form

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[46]M. Friemouth, S. L. Hamond, T. Edgar, D. McDonald, and E. L. Fink, "Factors Explaining Intent, Discussion, and Use of Condoms in First-Time Sexual Encounters," in Health Education Research: Theory and Press, eds. M. Friemouth, S. L. Hamond, T. Edgar, D. McDonald, and E. L. Fink (Hillandale, NJ: Lawrence Erlboum Associates, 1990), 92-110.

[47]J. A. Cantania, T. J. Coates, R. M. Greenblatt, and J. Miller, "Predictors of Condom Use and Multiple Partnered Sex Among Sexually Active Adolescent Women: Implications for AIDS-Related Health Interventions," Journal of Sex Research 4 (1989): 514-524.

[48]M. W. Ross, "Personality Factors That Differentiate Homosexual Men With Positive and Negative Attitudes Toward Condom Use," NY State Journal of Medicine 88 (1988): 626-628.

of birth control, but they also reported greater skill than those who regularly used oral contraceptive.[49] Baffi and associates found that the assumption of widespread resistance to condom use may be due to the fact that they were more available. Yet, a large proportion of their sample of college students said that they preferred not to use condoms, 83% reported at the same time that they would not object if their partners made the suggestion.[50]

Theoretical Framework

This section is organized around three primary conceptual perspectives: a developmental perspective, cognitive theory, and an ecological systems model.

According to Phinney and Rotheram, the developmental perspective provides a framework for examining the influence of race and ethnicity on the psychosocial tasks of growing up in American society. Although the maturational processes are undeniably universal and occur with only minor variations across racial and cultural groups, these processes are subject to wide ethnic variations in their

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[49]G. Cvettkovich and B. Grote, "Psychosocial Maturity and Teenage Contraceptive Use: An Investigation of Decision-Making and Communication Skills," Population and Environment 4 (1981): 211-226.

[50]C. A. Baffi, K. K. Schoder, and K. J. Redican, "Factors Influencing Selected Heterosexual: Male College Students' Condom Use," Journal of American College Health 38 (1988): 1137-1144.

behavioral manifestations, their symbolic meanings, and societal responses.[51]

There are five psychosocial stages from birth to late adolescence, each one posing a specific developmental challenge for the growing child to master. Successful resolution of the psychosocial stages depends on a favorable interaction and will result in a balance of the sense of trust over mistrust in the infant, autonomy over shame and doubt in the toddler initiative over guilt in the preschool, industry over identity diffusion in the adolescent. Erickson points out that children from minority backgrounds may experience more difficulties in achieving those positive outcomes because of prejudice, discrimination, or barriers to full opportunity for personal growth.[52]

This framework enables social workers to evaluate the child's level of psychosocial development at various ages on the basis of certain salient characteristics such as independence competence and interpersonal skills, and sense of personal identity. It is also useful for assessing the child's relationships with significant others and adjustment to the environment. Erickson's psychosocial theory extends Freud's developmental emphasis over the lifespan focusing on

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[51]G. J. Phinney and M. J. Rotheram, Children's Ethnic Socialization: Pluralism and Developmental (Newbury Park, CA: Sage, 1987).

[52]E. H. Erickson, "Identity and the Life Cycle," Psychological Issues 1 (1959): 1.

the achievement of specific life-enhancing tasks. It provides the social worker with a framework for viewing important areas of psychosocial growth and development.

Beck believed that cognitive-structural theories should focus on how individuals develop a sense of meaning in the world. He was interested in the "automatic thoughts" of his clients.

> The basic theory of Beck's cognitive model of emotional disorders holds that in order to understand the nature of an emotional episode or disturbances, it is essential to focus on the cognitive content of an individual's reaction to the upsetting event or stream of thoughts. The goal is to change the way the client thinks.[53]

This is a technique that helps clients who ruminate about the past or have irrational thoughts to stop such self defeating behavior. Basically, the technique teaches the client to progress from outside control to inner control of negative thought patterns. The technique helps the client replace self-defeating thoughts with assertive, positive, or neutral ones. Cognitive therapy is very effective as a short-term treatment. It recognizes that behavior and perception play a reciprocal role in the process of change.

The ecological perspective as proposed by Bronfenbrenner[54] is useful in viewing the growing child and

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[53]A. T. Beck, Cognitive Therapy and Emotional Disorders (New York: International Universities Press, 1976), 135-168.

[54]U. Bronfenbrenner, The Ecology of Human Development Experiments by Nature and Design (Cambridge: Harvard University Press, 1979), 6-18.

adolescent as an active agent in a series of interlocking systems, ranging from microsystems of the family and the school to the macrosystem of governmental, social and economic policies. Each of these systems poses risks and opportunities for the child or adolescent interacting with the environment at successive developmental stages. This perspective is especially relevant for minority youth, since they form the setting for socialization. It is useful in analyzing the impact of poverty, discrimination, and social isolation on the psychosocial development and adjustment of minority youth.

The knowledge of HIV/AIDS, safe sex behaviors, and condom use is heavily impacted on how African-American male and female college students view themselves in relation to the disease. Several factors could have significant influence. These factors are social, psychological, physical and cultural.

The social influence may dictate how African-American college students view the disease. The psychological influence can best describe how African-American college students view themselves in relation to the disease. The physical influence may affect how African-American college students perceive physical satisfaction in relation to condom use. Last but not least, the cultural influence and how it relates to how men and women perceive their gender

roles and sexuality could have lasting impact on the power to change thought patterns and encourage safe sex behavior.

Definitions of Concepts

AIDS (Acquired Immune Deficiency Syndrome): A viral disease that impairs the body's ability to fight disease. AIDS is caused by the Human Immunodeficiency Virus (HIV). People with AIDS are susceptible to a wide range of unusual and life threatening diseases. These diseases can often be treated, but there is no successful treatment for the underlying immune deficiency caused by the virus.

Condoms: Condoms are sometimes called "rubbers". Condoms fit tightly on a man's penis. Condoms are used in sex to keep the semen of a man from getting into the body of his sex partner. Condoms can keep the HIV virus from person to his sex partner.

HIV (Human Immunodeficiency Virus): The name officially chosen in August, 1986 for the virus that causes AIDS.

Knowledge: Having ability to know facts, information.

Safe Sex Behavior: Sexual contact that is secure from danger and risk of disease through protection and preventive measures such as proper condom use.

Statement of Hypothesis

There is no significant statistical difference between HIV/AIDS knowledge, sexual behavior and condom use among African-American male and female college students.

CHAPTER THREE

METHODOLOGY

Research Design

This study is a descriptive exploratory study intended to sketch the dimensions of the new crisis of African-American college students. It is intended to reveal the major factors that contributes to the disproportionate number of African-American youth developing HIV/AIDS.

This study will focus on HIV/AIDS knowledge, sexual behavior, and condom use among African-American college students.

Sampling

The nonprobability convenience sample was used for this study. The sample consisted of 15 female and 15 male African-American college students, 18 years of age and older, attending Clark Atlanta University, Spelman and Morehouse Colleges during the Summer session of 1996. The gathering of data was extended over a period of days and the subjects participated without difficulty.

Data Collection Procedure (Instrumentation)

Data was collected through the use of a questionnaire to ascertain information regarding HIV/AIDS knowledge, sexual behavior and condom use among African-American college students. Contact was made with several faculty members, requesting permission to administer this

questionnaire to students for the purpose of this research. Human subject rights were addressed and strictly adhered to. Other students were recruited by a direct request to students. Confidentiality was ensured and participants had the option to participate or decline participation.

The purpose and goals of the research was explained to all participants by the two persons administering the questionnaire. Instructions for completing the questionnaire were clearly given. Expressions of appreciation was given by the two persons administering the questionnaire. The questionnaire took approximately 10 minutes to complete.

The measuring instrument utilized in this research was taken from The Evaluation Manual on HBCU campuses, prepared by the National Association of Equal Opportunity in Higher Education (NAFEO) Black Higher Education Center.[1] A list of 73 item instrument designed to measure HIV/AIDS knowledge, sexual behavior, and condom use.

The measuring instrument was adapted for this research study. Measuring instrument utilized 38 questions of which six were demographic questions, ten questions measured HIV/AIDS knowledge, eight questions measured sexual

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[1]National Association for Equal Opportunity in Higher Education (NAFEO) Black Higher Education Center, Evaluating HIV/AIDS/STD Prevention Programs on HBCU Campuses: An Evaluation Manual (Washington, DC: National Association for Equal Opportunity in Higher Education (NAFEO) Black Higher Education Center, 1995), 41-58.

behavior and fourteen questions measured condom use. Subjects were asked to choose one response from a number of predetermined electives. Clear instructions for completion of the questionnaire provided.

The questionnaire contained four sections: (1) demographics, (2) HIV/AIDS knowledge, (3) sexual behavior, and (4) condom use.

The validity and reliability of this adapted instrument are not known at this time. The participants did not express anxiety or raise any specific questions about sharing this information.

Data Analysis

The data was analyzed using SPSSX batched system of the Vax Computer System at Clark Atlanta University. Descriptive statistics, percentages, frequency distribution, standard deviation and t-test were used.

CHAPTER FOUR

PRESENTATION OF RESULTS

The data collected in this study provides a profile of 29 African-American college students who participated in the self-administered questionnaire on HIV/AIDS knowledge, sexual behavior and condom use among African-American male and female college students. Information in this chapter has been arranged in four sections: (1) demographics, (2) HIV/AIDS knowledge, (3) sexual behavior, and (4) condom use.

Null Hypothesis

H1: There is no significant statistical difference between HIV/AIDS knowledge, sexual behavior and condom use among African-American male and female college students.

Demographic Data

TABLE 1

FREQUENCY TABLE FOR AGE
(N = 29)

Age	Frequency	Percentage
18 - 24	13	44.8
25 - 31	5	17.2
32 - 38	4	13.8
38 - 44	6	20.7
Missing Value	1	3.4
Total	29	100.0

The table shows that 44.8% (13) of the respondents were 18-24 years old; 17.2% (5) were 25-31; 13.8% (4) were 32-38; 20.7% (6) were in age range of 38-44; while 3.4% (1) did not respond.

TABLE 2

FREQUENCY TABLE FOR GENDER
(N = 29)

Gender	Frequency	Percentage
Male	14	48.3
Female	15	51.7
Total	29	100.0

In response to the question of gender, 48.3% (14) of respondents were male; while 51.7% (15) were female.

TABLE 3

FREQUENCY OF MARITAL STATUS
(N = 29)

Marital Status	Frequency	Percentage
Single	21	72.4
Married	5	17.2
Divorced	2	6.9
Living with someone	1	3.4
Total	29	100.0

The table indicates that 72.4% (21) respondents were single; 17.2% (5) were married; 6.9% (2) were divorced; while 3.4% (1) were living with someone.

TABLE 4

FREQUENCY FOR HIGHEST GRADE COMPLETED (N = 29)

Grade Level	Frequency	Percentage
Sophomore	8	27.6
Junior	7	24.1
Senior	4	13.8
2nd year Graduate	10	34.5
Total	29	100.0

The respondents replied to the question of classification, 27.6% (8) of the respondents were Sophomore; 24.1% (7) of the respondents were Junior; 13.8% (4) were Senior; while 34.5% (10) were Second Year Graduate Students.

TABLE 5

FREQUENCY TABLE FOR CURRENT LIVING STATUS (N = 29)

Living Status	Frequency	Percentage
Dorm Alone	1	3.4
Campus Alone	1	3.4
Off-Campus Alone	4	13.8
Off-Campus Shared	22	75.9
Missing Value	1	3.4

Respondents replied to the question of living status as follows: 3.4% (1) of the respondents lived in the dorm alone; 13.8% (4) of the respondents lived off campus alone; 75.9% (22) of the respondents lived off campus shared; while 3.4% (1) were of missing value.

TABLE 6

FREQUENCY TABLE FOR STUDENT STATUS (N = 29)

Student Status	Frequency	Percentage
In State	14	51.7
Out of State	14	48.3
Total	29	100.0

In response to state residency, 51.7% (15) of the respondents were in state students, while 48.3% (14) of the respondents were out of state students.

Knowledge

TABLE 7

YOU CAN GET AIDS IF YOU HAVE SEX ONLY ONCE WITHOUT A CONDOM (N = 29)

Value Labels	Frequency	Percentage
Sure True	22	75.9
Think True	2	6.9
Sure False	3	10.3
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.6923	1.494
Women	1.3571	1.082

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.67	25	.508	.66	21.77	.514

The respondents replied as follows: 75.9% (22) were sure the statement, "You can get AIDS if you have sex only once," was true; 6.9% (2) thought the statement to be true, while 10.3% (3) were sure the statement to be false; 6.9% (2) were of missing value. Men scored a mean of 1.6923 and a standard deviation of 1.494 while women scored a mean of 1.3571 and a standard deviation of 1.082. There are no statistical significant observed mean differences between the participants scores with reference to their response: "You can get AIDS if you have sex only once without a condom."

TABLE 8

A PERSON CAN "PASS" AN HIV-ANTIBODY TEST BUT STILL BE INFECTED WITH HIV (N = 29)

Value Labels	Frequency	Percentage
Sure True	22	75.9
Think True	2	6.9
Sure False	3	10.3
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.2308	.599
Women	1.2143	.426

TABLE 8 (continued)

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.08	25	.935	.08	21.53	.936

Respondents replied to the following: 75.9% (22) were sure the statement, "A person can pass an HIV-antibody test but still be infected with HIV," was true; 6.9% (2) thought the statement to be true; 10.3% of the respondents were sure the statement to be false; 6.9% (2) were of missing value. Men scored a mean score of 1.2308 and a standard deviation of .599 while women scored a mean score 1.2143 and a standard deviation of .426. There are no statistical significant observed mean differences between the participants scores with reference to their response: "A person can pass an HIV-antibody test but still be infected with HIV."

TABLE 9

CONDOMS ARE 100 PERCENT EFFECTIVE IN PREVENTING HIV (N = 29)

Value Labels	Frequency	Percentage
Think True	2	6.9
Don't Know	1	3.4
Think False	4	13.8
Sure False	20	69.0
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	4.6923	.630
Women	4.4286	1.089

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.76	25	.453	.78	21.10	.446

Out of the respondents, 6.9% (2) thought the statement, "Condoms are 100% effective," to be true; 3.4% (1) responded don't know; 13.8% (4) thought the statement to be false, while 6.9% (2) were of missing value. Men scored a mean of 4.6923 and a standard deviation of .630 while women scored a mean of 4.4286 and a standard deviation of

1.089. There are no statistical significant observed mean differences between the participants scores with reference to their response: "Condoms are 100 percent effective in preventing HIV."

TABLE 10

MALES CAN PASS HIV ON TO OTHERS THROUGH THEIR SEMEN (N = 29)

Value Labels	Frequency	Percentage
Sure True	23	79.3
Think True	2	6.9
Sure False	2	6.9
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.3846	1.121
Women	1.3571	1.082

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.06	25	.949	.06	24.69	.949

The respondents replied as follows: 79.3% (23) were sure the statement, "Males can pass HIV on to others through

their semen," was true; 6.9% (2) thought the statement to be true, while 6.9% (2) were sure the statement to be false; 6.9% (2) were of missing value. Men scored a mean of 1.3846 and a standard deviation of 1.121 while women scored a mean of 1.357 with a standard deviation of 1.082. There are no statistical significant observed mean differences between the participants scores with reference to their response: "Males can pass HIV on to others through their semen."

TABLE 11

YOU CAN GET HIV BY SITTING ON THE SEAT OF A TOILET THAT A PERSON WITH AIDS HAS USED (N = 29)

Value Labels	Frequency	Percentage
Sure True	1	3.4
Think True	1	3.4
Don't Know	5	17.2
Think False	3	10.3
Sure False	17	58.6
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	4.3846	.870
Women	4.1429	1.351

TABLE 11 (continued)

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.55	25	.589	.56	22.37	.583

In response to the table above, 3.4% (1) were sure the statement, "You can get HIV by sitting on the seat of a toilet that a person with AIDS has used," was true; 3.4% (1) thought the statement to be true; 17.2% (5) don't know; 10.3% (3) thought the statement to be false, while 58.6% (17) were sure the statement was false; 6.9% (2) were of missing value. Men scored a mean of 4.3846 and a standard deviation of .870 while women scored a mean of 4.1429 and a standard deviation of 1.351. There are no statistical significant observed mean differences between the participants scores with reference to their response: "You can get HIV by sitting on the seat of a toilet that a person with AIDS has used."

TABLE 12

ABSTAINING FROM SEX AND DRUGS IS THE BEST WAY FOR TEENAGERS TO AVOID GETTING HIV (N = 29)

Value Labels	Frequency	Percentage
Sure True	24	82.8
Think True	2	6.9
Sure False	1	3.4
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.0769	.277
Women	1.3571	1.082

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.91	25	.374	-.94	14.83	.364

The table shows 82.8% (24) were sure the statement, "Abstaining from sex and drugs as the best way for teenagers to avoid getting HIV," was true; 6.9% (2) thought the statement to be true; 3.4% (1) were sure the statement was false, while 6.9% (2) were of missing value. Men scored a mean of 1.0769 and a standard deviation of .277, while women scored a mean of 1.3571 and a standard deviation of 1.082.

There are no statistical significant observed mean differences between the participants scores with reference to their response: "Abstaining from sex and drugs is the best way for teenagers to avoid getting HIV."

TABLE 13

YOU CAN GET HIV FROM DRINKING FROM THE SAME GLASS OR WATER FOUNTAIN THAT A PERSON WITH AIDS DRANK FROM (N = 29)

Value Labels	Frequency	Percentage
Sure True	1	3.4
Think True	2	6.9
Don't Know	6	20.7
Think False	1	3.4
Sure False	17	58.6
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	4.0000	1.155
Women	4.2857	1.326

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.60	25	.557	-.60	24.91	.555

The above table indicates: 3.4% (1) of the respondents was sure the statement, "You can get HIV from drinking from a drinking glass or water fountain that a person with AIDS drank from," was true; 6.9% (2) of the respondents thought the statement to be true; 20.7% (6) of the respondents don't know; 3.4% (1) thought the statement to be false; 58.6% (17) were sure the statement to be false, while 6.9% (2) were of missing value. Men scored a mean of 4.0000 and a standard deviation of 1.155, while women scored a mean of 4.2857 and a standard deviation of 1.326. There are no statistical significant observed mean differences between the participants scores with reference to their response: "You can get HIV from drinking from a drinking glass or water fountain that a person with AIDS drank from."

TABLE 14

HIV CAN BE FOUND IN VAGINAL FLUIDS, SEMEN, AND BLOOD (N = 29)

Value Labels	Frequency	Percentage
Sure True	24	82.8
Think True	1	3.4
Sure False	2	6.9
Missing Value	2	6.9
Total	29	100.0

TABLE 14 (continued)

Groups	Mean	Standard Deviation
Men	1.0769	.277
Women	1.5714	1.453

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-1.21	25	.239	-1.25	14.02	.232

Respondents replied as follows: 82.8% (24) of the respondents were sure the statement, "HIV can be found in vaginal fluids, semen, and blood," was true; 3.4% (1) of the respondents was sure the statement to be true; 6.9% (2) of the respondents thought the statement to be false, while 6.9% (2) were of missing value. Men scored a mean of 1.0769 and a standard deviation of .277, while women scored a mean of 1.5714 and a standard deviation of 1.453. There are no statistical significant observed mean differences between the participants scores with reference to their response: "HIV can be found in vaginal fluids, semen, and blood."

TABLE 15

A PERSON CAN GET HIV SHARING DRUG NEEDLES
(N = 29)

Value Labels	Frequency	Percentage
Sure True	26	89.7
Think True	1	3.4
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.0769	.277
Women	1.0000	.000

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob

No variance for independent sample t-test--one or more samples has no variance.

The replies of the respondents indicate: 89.7% (26) of the respondents were sure the statement, "A person can get HIV by sharing drug needles," was true; 3.4% (1) of the respondents thought the statement to be false, while 6.9% (2) were of missing value. Men scored a mean of 1.0769 and a standard deviation of .277, while women scored a mean of 1.0000 and a standard deviation of .000. There are no statistical significant observed mean differences between

the participants scores with reference to their response: "A person can get HIV by sharing drug needles."

TABLE 16

YOU CAN GET HIV FROM A MOSQUITO BITE
(N = 29)

Value Labels	Frequency	Percentage
Sure True	3	10.3
Think True	3	10.3
Don't Know	6	20.7
Think False	4	13.8
Sure False	11	37.9
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	3.4615	1.506
Women	3.7857	1.369

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.59	25	.563	-.58	24.28	.565

Out of the respondents, 10.3% (3) of the respondents were sure the statement, "You can get HIV from a mosquito

bite," was true; 10.3% (3) of the respondents thought the statement to be true; 20.7% (6) don't know; 13.8% (4) thought the statement to be false; 37.9% respondents were sure the statement to be false; while 6.9% (2) were of missing value. Men scored a mean of 3.4615 and a standard deviation of 1.506, while women scored a mean of 3.7857 and a standard deviation of 1.369. There are no statistical significant observed mean differences between the participants scores with reference to their response: "You can get HIV from a mosquito bite."

Safe Sex

TABLE 17

HAVE YOU EVER HAD SEXUAL INTERCOURSE?
(N = 29)

Value Labels	Frequency	Percentage
Yes	25	86.2
No	2	6.9
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.0769	.277
Women	1.0714	.267

TABLE 17 (continued)

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.05	25	.959	.05	24.68	.959

The respondents replied as follows: 86.2% (25) of the respondents responded yes to the question, "Have you ever had sexual intercourse?," 6.9% (2) responded no to the question, while 6.9% (2) were of missing value. Men scored a mean of 1.0769 and a standard deviation of .277, while women scored a mean of 1.0714 and a standard deviation of .267. There are no statistical significant observed mean differences between the participants scores with reference to their response: "Have you ever had sexual intercourse?"

TABLE 18

HOW MANY PERSONS HAVE YOU HAD SEX WITH IN ONE LIFETIME (N = 29)

Value Labels	Frequency	Percentage
1	1	3.4
2	3	10.3
3 - 5	9	31.0
6 - 10	5	17.2
21 - 50	2	6.9
More than 50	2	6.9
DK	1	3.4
NA	5	17.2
Missing Value	1	3.4
Total	29	100.0

TABLE 18 (continued)

Groups	Mean	Standard Deviation
Men	5.0769	2.397
Women	4.4667	2.800

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.61	26	.544	.62	26.00	.540

The above table indicates: 3.4% (1) of the respondents responded that they had 1 sexual partner in their lifetime; 10.3% (3) of the respondents stated that they had 2 sexual partners; 31% (19) respondents stated that they had 3-5 sexual partners; 17.2% (5) of the respondents stated they had 6-10 sexual partners; 6.9% (2) of the respondents stated they had 21-50 sexual partners; 6.9% (2) of the respondents stated they had more than 50 sexual partners; 3.4% (1) of the respondents stated they don't know; 17.2% (5) of the respondents stated NA; while 3.4% (1) were of missing value. Men scored a mean of 5.0769 and a standard deviation of 2.397, while women scored a mean of 4.4667 and a standard deviation of 2.800. There are no statistical significant observed mean differences between the participants scores with reference to their response: "How many persons have you had sex with in one lifetime?"

TABLE 19

HAVE YOU HAD SEX IN THE PAST MONTH?
(N = 29)

Value Labels	Frequency	Percentage
Yes	13	44.8
No	13	44.8
NA	2	6.9
Missing Value	1	3.4
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.6154	.650
Women	1.6000	.632

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.06	26	.950	.06	25.21	.950

As shown in Table 19, 44.8% (13) of the respondents answered yes to the question, "Have you had sex in the past month"; 44.8% (13) answered no; 6.9% (2) replied NA, while 3.4% (1) was of missing value. Men scored a mean of 1.6154 and a standard deviation of .650, while women scored a mean of 1.6000 and a standard deviation of .632. There are no statistical significant observed mean differences between

the participants scores with reference to their response: "Have you had sex in the past month?"

TABLE 20

HAVE YOU HAD ORAL INTERCOURSE IN THE PAST MONTH? (N = 29)

Value Labels	Frequency	Percentage
Yes	9	31.0
No	18	62.1
NA	1	3.4
Missing Value	1	3.4
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.6923	.630
Women	1.7333	.458

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.20	26	.844	-.19	21.60	.848

As shown in Table 20, 31% (9) answered yes to the question, "Have you had oral sex in the past month?", 62.1% (18) answered no; 3.4% (1) answered NA; while 3.4% (1) was of missing value. Men scored a mean of 1.6923 and a

standard deviation of .630, while women scored a mean of 1.7333 and a standard deviation of .458. There are no statistical significant observed mean differences between the participants scores with reference to their response: "Have you had oral sex in the past month?"

TABLE 21

DO YOU HAVE A MAIN STEADY SEXUAL PARTNER?
(N = 29)

Value Labels	Frequency	Percentage
Yes	18	62.1
No	7	24.1
NA	3	10.3
Missing Value	1	3.4
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.4615	.660
Women	1.4667	.743

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.02	26	.985	-.02	25.98	.985

Respondents replied as follows: 62.1% (18) of the respondents answered yes to the question, "Do you have a main steady sexual partner?"; 24.1% (7) answered no to the question; 10.3% (3) responded NA; while 3.4% (1) was of missing value. Men scored a mean of 1.4615 and a standard deviation of .660, while women scored a mean of 1.4667 and a standard deviation of .743. There are no statistical significant observed mean differences between the participants scores with reference to their response: "Do you have a main steady sexual partner?"

TABLE 22

IN THE PAST MONTH, HOW MANY SEXUAL PARTNERS HAVE YOU HAD (N = 29)

Value Labels	Frequency	Percentage
1	19	65.5
2	2	6.9
3 - 5	1	3.4
NA	4	13.8
Missing Value	3	10.3
Total	29	100.0

Groups	Mean	Standard Deviation
Men	2.8462	3.508
Women	1.9231	2.216

TABLE 22 (continued)

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.80	24	.430	.80	20.26	.432

The table shows that 65.5% (19) of the respondents answered that, "In the past month," they had only 1 sexual partner; 6.9% (2) of the respondents answered 2; 3.4% (1) of the respondents stated they had 3-5 sexual partners; 13.8% (4) answered NA; while 10.3% (3) were of missing value. Men scored a mean of 2.8462 and a standard deviation of 3.508, while women scored a mean of 1.9231 and a standard deviation of 2.216. There are no statistical significant observed mean differences between the participants scores with reference to their response: "In the past month, how many sexual partners have you had?"

TABLE 23

IN THE PAST MONTH, WHENEVER YOU HAD SEX, HOW OFTEN HAD YOU BEEN DRINKING ALCOHOL BEFORE OR DURING SEX
(N = 29)

Value Labels	Frequency	Percentage
Every time	1	3.4
Less than half time	4	13.8
Never	14	48.3
DK	1	3.4
NA	7	24.1
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	5.2857	1.069
Women	5.3846	1.261

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.22	25	.827	-.22	23.64	.829

In response to the question, the responses were: 3.4% (1) of the respondents replied they had been drinking alcohol before sex every time; 13.8% (4) of the respondents answered less than half time; 48.3% (14) replied never; 3.4%

(1) answered DK; 24.1% (7) replied NA; while 6.9% (2) were of missing value. Men scored a mean of 5.2857 and a standard deviation of 1.069, while women scored a mean of 5.3846 and a standard deviation of 1.261. There are no statistical significant observed mean differences between the participants scores with reference to their response: "In the past month, whenever you had sex, how often had you been drinking alcohol before or during sex?"

TABLE 24

IN THE PAST MONTH, WHENEVER YOU HAD SEX, HOW OFTEN HAD YOU BEEN USING MARIJUANA OR OTHER DRUGS BEFORE OR DURING SEX?
(N = 29)

Value Labels	Frequency	Percentage
More than half time	1	3.4
Less than half time	5	17.2
DK	20	69.0
NA	1	3.4
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	5.4286	.938
Women	5.6154	1.261

TABLE 24 (continued)

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.44	25	664	-.43	22.11	.668

The question was completed as follows: 3.4% (1) respondents replied more than half time to the question, "In the past month, how often was marijuana or other drugs used before or during sex?"; 17.2% (5) replied less than half the time; 69% (20) replied DK; 3.4% (1) replied NA; while 6.9% (2) were of missing value. Men scored a mean of 5.4286 and a standard deviation of .938, while women scored a mean of 5.6154 and a standard deviation of 1.261. There are no statistical significant observed mean differences between the participants scores with reference to their response: "In the past month, whenever you had sex, how often had you been using marijuana or other drugs before or during sex?"

Condom Use

TABLE 25

THE LAST TIME YOU HAD SEXUAL INTERCOURSE WITH YOUR MAIN PARTNER, DID YOU USE A CONDOM (N = 29)

Value Labels	Frequency	Percentage
Yes	12	41.4
No	15	51.7
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.6429	.497
Women	1.4615	.519

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.93	25	.363	.93	24.65	.365

Table 25 indicates that 41.4% (12) answered yes to the question, "The last time you had sexual intercourse with your main partner did you use a condom?"; 51.7% (15) of the respondents replied no; while 6.9% (2) were of missing value. Men scored a mean of 1.6429 and a standard deviation of .497, while women scored a mean of 1.4615 and a standard

deviation of .519. There are significant observed mean differences between the participants scores with reference to their response: "The last time you had sexual intercourse with your main partner, did you use a condom?"

TABLE 26

IN GENERAL, WHEN YOU HAVE SEX WITH YOUR MAIN PARTNER, HOW OFTEN DO YOU USE A CONDOM? (N = 29)

Value Labels	Frequency	Percentage
Never	9	31.0
Almost Never	3	10.3
Sometimes	2	6.9
Almost Every time	6	20.7
Every time	6	20.7
Missing Value	3	10.3
Total	29	100.0

Groups	Mean	Standard Deviation
Men	2.6923	1.653
Women	3.0769	1.706

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.58	24	.565	-.58	23.98	.565

As shown in Table 26, 31% (9) of the respondents replied never to the question, "In general when you have sex with your main partner, how often do you use a condom?"; 10.3% (3) of the respondents replied almost never; 6.9% (2) replied sometimes; 20.7% (6) respondents replied almost every time; 20.7% (6) replied every time; while 10.3% (3) were of missing value. Men scored a mean of 2.6923 and a standard deviation of 1.653, while women scored a mean of 3.0769 and a standard deviation of 1.706. There are significant observed mean differences between the participants scores with reference to their response: "In general, when you have sex with your main partner, how often do you use a condom?"

TABLE 27

IN THE PAST MONTH, WHEN YOU HAD SEX WITH YOUR MAIN PARTNER, HOW OFTEN DID YOU USE CONDOMS? (N = 29)

Value Labels	Frequency	Percentage
Never	9	31.0
Almost Never	2	6.9
Almost Every time	6	20.7
Every time	6	20.7
Missing Value	6	20.7
Total	29	100.0

TABLE 27 (continued)

Groups	Mean	Standard Deviation
Men	2.7692	1.739
Women	3.1000	1.853

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.44	21	.665	-.44	18.84	.668

As shown in Table 27, 31% (9) respondents replied never to the question, "In the past month, when you had sex with your main partner, how often did you use a condom?"; 6.9% (2) respondents replied almost never; 20.7% (6) were of missing values. Men scored a mean of 2.7692 and a standard deviation of 1.739, while women scored a mean of 3.1000 and a standard deviation of 1.853. There are significant observed mean differences between the participants scores with reference to their response: "In the past month, when you had sex with your main partner, how often did you use condoms?"

TABLE 28

HOW LONG HAVE YOU BEEN USING CONDOMS WHEN YOU HAVE SEX WITH YOUR PARTNER?
(N = 29)

Value Labels	Frequency	Percentage
1 month or less	5	17.2
More than 1 month but less than 3 months	2	6.9
Less than 3 months	13	44.8
Missing Value	9	31.0
Total	29	100.0

Groups	Mean	Standard Deviation
Men	2.3333	.866
Women	2.4545	.934

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.30	18	.769	-.30	17.67	.767

The respondents replied as follows: 17.2% (5) of the respondents replied 1 month or less to the question, "How long have you been using condoms when having sex with your main partner?"; 6.9% (2) of the respondents replied less than 3 months; while 31% (9) were of missing value. Men scored a mean of 2.333 and a standard deviation of .866,

while women scored a mean of 2.4545 and a standard deviation of .934. There are significant observed mean differences between the participants scores with reference to their response: "How long have you been using condoms when you have sex with your partner?"

TABLE 29

IN THE NEXT THREE MONTHS, HOW LIKELY DO YOU THINK IT IS THAT YOU WILL START USING CONDOMS EVERY TIME YOU HAVE SEX WITH YOUR PARTNER? (N = 29)

Value Labels	Frequency	Percentage
Extremely sure I will	13	44.8
Somewhat sure I will	4	13.8
Undecided	2	6.9
Somewhat sure I couldn't	4	13.8
Extremely sure I couldn't	2	6.9
Missing Value	4	13.8
Total	29	100.0

Groups	Mean	Standard Deviation
Men	2.3333	1.670
Women	1.9231	1.188

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.71	23	.483	.70	19.73	.490

Out of the respondents, 44.8% (13) of the respondents replied, extremely sure I will to the question, "In the next three months, how likely is it that you will start using condoms every time you have sex with your partner?"; 13.8% (4) of the respondents replied somewhat sure I will; 6.9% (2) of the respondents replied undecided; 13.8% (4) of the respondents replied somewhat sure I couldn't; 6.9% (2) of the respondents replied extremely sure I couldn't; while 13.8% (4) were of missing values. Men scored a mean of 2.333 and a standard deviation of 1.670, while women scored a mean of 1.9231 and a standard deviation of 1.188. There are significant observed mean differences between the participants scores with reference to their response: "In the next three months, how likely do you think it is that you will start using condoms every time you have sex with your partner?"

TABLE 30

"WHAT IF?"
(N = 29)

Value Labels	Frequency	Percentage
Extremely sure I could	19	65.5
Somewhat sure I could	5	17.2
Undecided	1	3.4
Extremely sure I couldn't	1	3.4
Missing Value	3	10.3
Total	29	100.0

TABLE 30 (continued)

Groups	Mean	Standard Deviation
Men	1.6923	1.182
Women	1.1538	.376

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
1.57	24	.131	1.57	14.40	.139

The replies of the respondents indicate: 65.5% (19) of the respondents replied extremely sure I could to the "What if" question; 17.2% (5) of the respondents replied somewhat sure I could; 3.4% (1) of the respondents replied undecided; 3.4% (1) of the respondents replied extremely sure I couldn't; while 10.3% (3) were of missing value. Men scored a mean of 1.6923 and a standard deviation of 1.182, while women scored a mean of 1.1538 and a standard deviation of .376. There are significant observed mean differences between the participants scores with reference to their response: "What if?"

TABLE 31

THE LAST TIME YOU HAD SEX WITH SOMEONE LIKE THIS WHO'S NOT YOUR MAIN PARTNER, DID YOU USE A CONDOM? (N = 29)

Value Labels	Frequency	Percentage
Yes	22	75.9
No	1	3.4
Missing Value	6	20.7
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.0909	.302
Women	1.0000	.000

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob

No variance for independent sample t-test--one or more samples has no variance.

Table 31 indicates 75.9% (22) of the respondents replied yes to the question, "The last time you had sexual intercourse with someone like this, who's not your main partner, did you use a condom?"; 3.4% (1) of the respondents replied no; while 20.7% (6) were of missing value. Men scored a mean of 1.0909 and a standard deviation of 1.302, while women scored a mean of 1.0000 and a standard deviation

of .000. There are significant observed mean differences between the participants scores with reference to their response: "The last time you had sex with someone like this, who's not your main partner, did you use a condom?"

TABLE 32

IN GENERAL, WHEN YOU HAVE SEX WITH SOMEONE WHO'S NOT YOUR MAIN PARTNER, HOW OFTEN DO YOU USE A CONDOM?
(N = 29)

Value Labels	Frequency	Percentage
Never	1	3.4
Almost never	1	3.4
Sometimes	1	3.4
Almost every time	2	6.9
Every time	18	62.1
Missing Value	6	20.7
Total	29	100.0

Groups	Mean	Standard Deviation
Men	4.4545	1.036
Women	4.5833	1.165

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.28	21	.783	-.28	20.99	.782

In response to the above table, 3.4% (1) of the respondents replied never to the question, "In general, when you have sex with someone who's not your main partner, how often do you use a condom?"; 3.4% (1) of the respondents replied almost never; 3.4% (1) of the respondents replied sometimes; 6.9% (2) of the respondents replied almost every time; 62.1% (18) of the respondents replied every time; while 20.7% (6) were of missing value. Men scored a mean of 4.4545 and a standard deviation of 1.036, while women scored a mean of 4.5833 and a standard deviation of 1.165. There are significant observed mean differences between the participants scores with reference to their response: "In general, when you have sex with someone who's not your main partner, how often do you use a condom?"

TABLE 33

IN THE PAST MONTH, WHEN YOU HAD SEX WITH SOMEONE WHO'S NOT YOUR MAIN PARTNER, HOW OFTEN DID YOU USE A CONDOM? (N = 29)

Value Labels	Frequency	Percentage
Almost never	1	3.4
Almost every time	2	6.9
Every time	13	44.8
Missing Value	13	44.8
Total	29	100.0

TABLE 33 (continued)

Groups	Mean	Standard Deviation
Men	4.5714	1.134
Women	4.7778	.441

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.50	14	.623	-.46	7.42	.662

Table 33 shows that: 3.4% (1) of the respondents replied almost never to the question, "In the past month when you had sex with someone who was not their main partner, how often did you use a condom?"; 6.9% (2) of the respondents replied almost every time; 44.8% (13) of the respondents replied every time; while 44.8% (13) of the respondents were of missing value. Men scored a mean of 4.5714 and a standard deviation of 1.134, while women scored a mean of 4.7778 and a standard deviation of .441. There are significant observed mean differences between the participants scores with reference to their response: "In the past month when you had sex with someone who's not your main partner, how often did you use a condom?"

TABLE 34

HOW LONG HAVE YOU BEEN USING CONDOMS WHEN HAVING SEX WITH SOMEONE WHO'S NOT YOUR MAIN PARTNER? (N = 29)

Value Labels	Frequency	Percentage
1 month or less	2	6.9
More than 1 month but less than 3 months	2	6.9
3 months or less	15	51.7
Missing Value	10	34.5
Total	29	100.0

Groups	Mean	Standard Deviation
Men	2.8571	.378
Women	2.5833	.793

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.85	17	.406	1.01	16.62	.325

The respondents replied as follows: 6.9% (2) of the respondents replied 1 month or less to the question, "How long have you been using condoms when you have sex with someone who's not your main partner?"; 6.9% (2) of the respondents replied more than 1 month but less than 3 months; 51.7% (15) of the respondents replied 3 months or

less; while 34.5% (10) were of missing value. Men scored a mean of 2.8571 and a standard deviation of .378, while women scored a mean of 2.5833 and a standard deviation of .793. There are significant observed mean differences between the participants scores with reference to their response: "How long have you been using condoms when having sex with someone who's not your main partner?"

TABLE 35

IN THE NEXT THREE MONTHS, HOW LIKELY DO YOU THINK IT IS THAT YOU WILL START USING A CONDOM EVERY TIME YOU HAVE SEX WITH SOMEONE WHO IS NOT YOUR MAIN PARTNER? (N = 29)

Value Labels	Frequency	Percentage
Extra sure	19	65.5
Somewhat sure	2	6.9
Undecided	1	3.4
Missing Value	7	24.1
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.1000	.316
Women	1.2500	.622

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.69	20	.498	-.73	16.90	.475

Out of the respondents, 65.5% (19) of the respondents replied extra sure to the question, "In the next three months, how likely do you think it is that you will start using a condom every time you have sex with someone who is not your main partner?"; 6.9% (2) of the respondents replied somewhat sure; 3.4% (1) of the respondents replied undecided; while 24.1% (7) were of missing value. Men scored a mean of 1.10000 and a standard deviation of .316, while women scored a mean of 1.2500 and a standard deviation of .622. There are significant observed mean differences between the participants scores with reference to their response: "In the next three months, how likely do you think it is that you will start using a condom every time you have sex with someone who is not your main partner."

TABLE 36

"WHAT IF?"
(N = 29)

Value Labels	Frequency	Percentage
Extremely sure	21	72.4
Somewhat sure	3	10.3
Extremely sure I couldn't	1	3.4
Missing Value	4	13.8
Total	29	100.0

TABLE 36 (continued)

Groups	Mean	Standard Deviation
Men	1.2500	.452
Women	1.3077	1.109

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.17	23	.868	-.17	16.14	.865

Table 36 shows that: 72.4% (21) of the respondents replied extremely sure to the "what if?" question; 10.3% (3) of the respondents replied somewhat sure; 3.4% (1) of the respondents replied extremely sure I couldn't; while 13.8% (4) were of missing value. Men scored a mean of 1.2500 and a standard deviation of .452, while women scored a mean of 1.3077 and a standard deviation of 1.109. There are significant observed mean differences between the participants scores with reference to their response: "What If?"

TABLE 37

CONDOMS ARE A GOOD CONVERSATION STARTER
(N = 29)

Value Labels	Frequency	Percentage
Agree	7	24.1
Disagree	19	65.5
Missing Value	3	10.3
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.8462	.376
Women	1.3846	.506

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
2.64	24	.014	2.64	22.13	.015

Respondents replied as follows: 24.1% (7) of the respondents agree with the statement, "Condoms are a good conversation starter"; 65.5% (19) of the respondents disagree with the statement; while 10.3% (3) were of missing value. Men scored a mean of 1.8462 and a standard deviation of .376, while women scored a mean of 1.3846 and a standard deviation of .506. There are significant observed mean differences between the participants scores with reference

to their response: "Condoms are a good conversation starter."

TABLE 38

CONDOMS ARE HARD TO PUT ON
(N = 29)

Value Labels	Frequency	Percentage
Agree	4	13.8
Disagree	22	75.9
Missing Value	3	10.3
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.7857	.426
Women	1.9167	.289

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.90	24	.376	-.93	22.90	.363

Respondents replied as follows: 13.8% (4) of the respondents agree with the statement, "Condoms are hard to put on"; 75.9% (22) of the respondents disagree with the statement; while 10.3% (3) were of missing value. Men scored a mean of 1.7857 and a standard deviation of .426,

while women scored a mean of 1.9167 and a standard deviation of .289. There are significant observed mean differences between the participants scores with reference to their response: "Condoms are hard to put on."

TABLE 39

CONDOMS SMELL BAD
(N = 29)

Value Labels	Frequency	Percentage
Agree	7	24.1
Disagree	19	65.5
Missing Value	3	10.3
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.6429	.497
Women	1.8333	.389

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-1.07	24	.294	-1.09	23.84	.285

Table 39 indicates that: 24.1% (7) of the respondents agree with the statement, "Condoms smell bad"; 65.5% (19) of the respondents disagree; while 10.3% (3) were

of missing value. Men scored a mean of 1.6429 and a standard deviation of .497, while women scored a mean of 1.833 and a standard deviation of .389. There are significant observed mean differences between the participants scores with reference to their response: "Condoms smell bad."

TABLE 40

CONDOMS ARE NO BIG DEAL
(N = 29)

Value Labels	Frequency	Percentage
Agree	10	34.5
Disagree	16	55.2
Missing Value	3	10.3
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.6429	.497
Women	1.5833	.515

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.30	24	.767	.30	23.12	.768

In response to the above table, 34.5% (10) of the respondents agree with the statement, "Condoms are no big deal"; 55.2% (16) of the respondents disagree; while 10.3% (3) were of missing value. Men scored a mean of 1.6429 and a standard deviation of .497, while women scored a mean of 1.5833 and a standard deviation of .515. There are significant observed mean differences between the participants scores with reference to their response: "Condoms are no big deal."

TABLE 41

CONDOMS PREVENT PREGNANCY
(N = 29)

Value Labels	Frequency	Percentage
Agree	24	82.8
Disagree	3	10.3
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.0714	.267
Women	1.1538	.376

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.66	25	.515	-.65	21.54	.521

The respondents replied as follows: 82.8% (24) of the respondents agree with the statement, "Condoms prevent pregnancy"; 10.3% (3) of the respondents disagree with the statement; while 6.9% (2) were of missing value. Men scored a mean of 1.0714 and a standard deviation of .267, while women scored a mean of 1.1538 and a standard deviation of .376. There are significant observed mean differences between the participants scores with reference to their response: "Condoms prevent pregnancy."

TABLE 42

CONDOMS ARE NOT 100% SAFE
(N = 29)

Value Labels	Frequency	Percentage
Agree	20	69.0
Disagree	7	24.1
Missing Value	2	6.9
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.3571	.497
Women	1.1538	.376

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
1.19	25	.245	1.20	24.05	.240

As shown in Table 42, 69% (20) of the respondents agree with the statement, "Condoms are not 100% safe"; 24.1% (7) of the respondents disagree with the statement; while 6.9% (2) were of missing value. Men scored a mean of 1.3571 and a standard deviation of .497, while women scored a mean of 1.1538 and a standard deviation of .376. There are significant observed mean differences between the participants scores with reference to their response: "Condoms are not 100% safe."

TABLE 43

CONDOMS COME OFF EASILY
(N = 29)

Value Labels	Frequency	Percentage
Agree	17	58.6
Disagree	7	24.1
Missing Value	5	17.2
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.5000	.522
Women	1.0833	.289

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
2.42	22	.024	2.42	17.15	.027

Out of the respondents, 58.6% (17) of the respondents agree with the statement, "Condoms come off easily"; 24.1% (7) of the respondents disagree with the statement; while 17.2% (5) were of missing value. Men scored a mean of 1.5000 and a standard deviation of .522, while women scored a mean of 1.0833 and a standard deviation of .289. There are significant observed mean differences between the participants scores with reference to their response: "Condoms come off easily."

TABLE 44

CONDOMS BREAK EASILY
(N = 29)

Value Labels	Frequency	Percentage
Agree	12	41.4
Disagree	12	41.4
Missing Value	5	17.2
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.7692	.439
Women	1.1818	.405

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
3.39	22	.003	3.41	21.81	.003

This table indicates that: 41.1% (12) of the respondents agree with the statement, "Condoms break easily"; 41.4% (12) of the respondents disagree with the statement; while 17.2% (5) were of missing value. Men scored a mean of 1.7692 and a standard deviation of .439, while women scored a mean of 1.1818 and a standard deviation of .405. There are significant observed mean differences between the participants scores with reference to their response: "Condoms break easily."

TABLE 45

CONDOMS ARE EASY TO USE
(N = 29)

Value Labels	Frequency	Percentage
Agree	20	69.0
Disagree	5	17.2
Missing Value	4	13.8
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.2308	.439
Women	1.1667	.389

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
.39	23	.704	.39	22.97	.702

As shown in Table 45, 69% (20) of the respondents agree with the statement, "Condoms are easy to use"; 17.2% (5) of the respondents disagree with the statement; while 13.8% (4) were of missing value. Men scored a mean of 1.2308 and a standard deviation of .439, while women scored a mean of 1.1667 and a standard deviation of .389. There are significant observed mean differences between the participants scores with reference to their response: "Condoms are easy to use."

TABLE 46

CONDOMS ARE FUNNY
(N = 29)

Value Labels	Frequency	Percentage
Agree	10	34.5
Disagree	15	51.7
Missing Value	4	13.8
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.5385	.519
Women	1.6667	.492

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.63	23	.533	-.63	22.98	.532

The above table displays: 34.5% (10) of the respondents agree with the statement, "Condoms are funny"; 51.7% (15) of the respondents disagree with the statement; while 13.8% (4) were of missing value. Men scored a mean of 1.5385 and a standard deviation of .519, while women scored a mean of 1.6667 and a standard deviation of .492. There are significant observed mean differences between the participants scores with reference to their response: "Condoms are funny."

TABLE 47

CONDOMS PREVENT STD
(N = 29)

Value Labels	Frequency	Percentage
Agree	24	82.8
Disagree	2	6.9
Missing Value	3	10.3
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.0714	.267
Women	1.0833	.289

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-.11	24	.914	-.11	22.72	.915

Table 47 indicates 82.8% (24) of the respondents agree with the statement, "Condoms prevent STD"; 6.9% (2) of the respondents disagree with the statement; while 10.3% (3) were of missing value. Men scored a mean of 1.0714 and a standard deviation of .267, while women scored a mean of 1.0833 and a standard deviation of .289. There are significant observed mean differences between the participants scores with reference to their response: "Condoms prevent STD."

TABLE 48

CONDOMS DON'T FEEL RIGHT
(N = 29)

Value Labels	Frequency	Percentage
Agree	12	41.4
Disagree	12	41.4
Missing Value	5	17.2
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.3846	.506
Women	1.6364	.505

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
-1.22	22	.237	-1.22	21.37	.237

In response to the question, 41.4% (12) of the respondents agree with the statement, "Condoms don't feel right"; 41.4% (12) of the respondents disagree with the statement; while 17.2% (5) were of missing value. Men scored a mean of 1.3846 and a standard deviation of .506, while women scored a mean of 1.6364 and a standard deviation of .505. There are significant observed mean differences between the participants scores with reference to their response: "Condoms don't feel right."

TABLE 49

IN THE PAST MONTH, HAVE YOU TALKED TO OR ASKED ANYONE ABOUT CONDOMS?
(N = 29)

Value Labels	Frequency	Percentage
Yes	9	31.0
No	19	65.5
Missing Value	1	3.4
Total	29	100.0

Groups	Mean	Standard Deviation
Men	1.7857	.426
Women	1.5714	.514

Pooled Variance Estimate			Separate Variance Estimate		
t-Value	Degrees of Freedom	2-Tail Prob	t-Value	Degrees of Freedom	2-Tail Prob
1.02	26	.240	1.20	25.14	.241

Table 49 shows that 31% (9) of the respondents replied yes to the question, "In the past month, have you talked to or asked anyone about condoms?"; 65.5% (19) of the respondents replied no; while 3.4% (1) were of missing value. Men scored a mean of 1.7857 and a standard deviation of .426, while women scored a mean of 1.5714 and a standard deviation of .514. There are significant observed mean differences between the participants scores with reference to their response: "In the past month, have you talked to or asked anyone about condoms?"

CHAPTER FIVE

SUMMARY AND CONCLUSIONS

The objective of this exploratory descriptive study was to assess the HIV/AIDS knowledge, sexual behavior and condom use among African-American college students. The beginning phase of this study allowed for the identification and presentation of demographic variables of African-American college students. The sample itself was largely African-American males and females.

The results must be interpreted within the limitations imposed by the sampling procedure. The sample of 30, ages 18- to 44-year-olds, data was derived from self-reports. Despite the limitations cited above, the findings clearly show that some African-American college students are at risk for HIV infection and they do engage in a broad variety of risk behaviors. This study highlights the need for research with this population. There is a need for social workers to know how their mental health and behavioral problems affect their ability to understand AIDS-related information and to act upon the knowledge in a responsible way. We need to know how their risk behavior changes over time in relation to exposure to knowledge about AIDS and their understanding of sexual behavior and condom use. Hope for behavior change must be tempered by our understanding of developmental theory and a recognition of the youths and young adults predilection to impulsive

behavior and their lack of concern with self-protection as indicated by low contraceptive use.

There was one hypothesis. In determining whether the null hypothesis was rejected or accepted, was addressed by utilizing various data analysis strategies. The result of the test of hypothesis was interpreted as follows: If the value of T is greater than the desired critical probability in terms of standard deviations, the difference between the sample mean and the hypothetical mean is significant, and the null hypothesis (that the difference between the two means is zero) is rejected. However, if the value of T is less than the critical probability, the difference between the two samples is not significant, but is due to sheer chance. The null hypothesis is, in that case accepted. The t-test was utilized to determine if identified variables reflected statistically significant results. The results of the study were then analyzed. Based on the results of the t-test analysis as shown in Chapter IV, the null hypothesis was supported. There was not enough evidence to the contrary to disprove that there is a significant difference in the HIV/AIDS knowledge, sexual behavior, and condom use among African-American male and female college students.

To attempt to address this and educate this population about HIV/AIDS high-risk behavior and not address the underlying conditions that encourage this behavior is self-defeating.

The results of this research on the exploratory descriptive study of HIV/AIDS knowledge, sexual behavior and condom use among African-American college students, indicated that the average African-American male within this population scored a mean of 1.6923 with a standard deviation of 1.494 in belief of the statement "You can get AIDS if you have sex only once without a condom." Women had a lower result in responding to the statement. Women scored a mean of 1.3571 and a standard deviation of 1.082. Overall in the area of HIV knowledge, men scored a mean of 24.5000 with a standard deviation of 3.423. The findings indicate that African-American male college students are more knowledgeable about HIV/AIDS. The women's score supports the findings of previous research that indicates that African-American women are the fastest growing population with HIV/AIDS. The t-test probability score was .514.

In the area of sexual behaviors, the results indicated that men scored a mean of 5.0769 with a standard deviation of 2.397 when responding to the question "How many persons have you had sex with in your lifetime?" Women scored a mean of 4.4667 and a standard deviation of 2.800. On average African-American male college students have more sexual partners than African-American female college students. Overall, men scored a mean of 22.000 with a standard deviation of 5.063; while women scored a mean of 24.3077 with a standard deviation of 6.933. This finding

indicates that women are less likely than men to participate in unsafe sexual behavior. The t-test probability score was .959.

Men scored a mean of 2.6923 and a standard deviation of 1.653 when asked the question "In general, when you have sex with your main partner, how often do you use a condom?", while women scored a mean of 3.0769 and a standard deviation of 1.706. The findings indicate that men are less likely to use a condom than women when having sex with their main partner. The t-test probability score was .365.

Furthermore, in the area of condom use, men scored a mean of 45.5714 and a standard deviation of 4.650; while women scored a mean of 48.6000 and a standard deviation of 3.507. The overall findings indicates that men are more likely than women not to use a condom.

In conclusion, the study has reviewed the conceptual frameworks of developmental perspective, cognitive theory, and ecological perspective as it related to African-American college students in regards to HIV/AIDS knowledge, sexual behavior, and condom use in order to identify implications for social work practice and future research. Research from outside of the social work profession is rapidly proliferating. The rapid proliferating body of HIV/AIDS literature can inform social work about potential risks for specific subgroups of minority youth.

Limitations of the Study

The limitations of this study include the small sample population size, the findings cannot be generalized to the total population. The findings of this particular study may only be directed toward the same population. The proportion of female respondents to male were 51.7 percent to 48.35 percent. The study did not concern itself with non-African-American college students. Urban African-American youth are at higher risk than average risk for HIV/AIDS because of their status in society. The results, therefore, should not be broadly generalized until replicated on different samples, at different points in time, and at different stages in the lifespan.

Suggested Research

The topic of HIV/AIDS knowledge, sexual behavior, and condom use among African-American college students is an important one especially in regards to social work students. Minority youth, according to some studies suggest that they are ill-informed about the effectiveness of condoms as a protective barrier against infection. The limited empirical social work data available suggest that the need is great for additional research with this population. There is a need to know, given their risk behavior, their rates of HIV infection over the coming years.

African-American students who may engage in indiscriminate sexual behavior, drug abuse, and other antisocial behavior should be the focus of future research.

CHAPTER SIX

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The study suggests that HIV/AIDS education program on the knowledge, sexual behavior, and condom use among African-American college students is indicated. Targeted programs are needed for African-American college students to prevent transmission of HIV/AIDS.

The magnitude of the problem for social work in the area of practice, research, knowledge and theory requires a sweeping response for this population.

Social workers have the skills, but need to increase their research knowledge about this population, the impact of HIV/AIDS on the students, family functioning. There is much room for social workers to expand their role in response to this population. African-American college students are not at risk because they are African-American. It is because they engage in unsafe sex, sharing needles, etc., all these factors must be taken into consideration by social workers to reduce and prevent HIV transmission.

The issues social workers need to address with this population are: powerlessness, gender inequity, poverty, discrimination and a host of psychosocial issues faced by Af rican-American students.

According to Brown, regardless of the practice setting, by 2000, the vast majority of social workers most likely will have worked with members of society who are

infected with, or affected by HIV/AIDS.[1] The Schools of Social Work must provide training to students and practitioners already in the field if social workers are to respond to this crisis.

Currently, social workers need to make major contributions to the field in the face of the growing AIDS pandemic among African-Americans. In order to provide culturally competent services to individuals who are African-American with HIV, social workers will need greater knowledge, skills, and understanding of the specific cultural and diversity dynamics of that group being served.

Regarding practice issues, several concepts provide the conceptual framework for this entry from this research study: developmental perspective, cognitive theory, and ecological perspective, cultural competency, and stigma. These concepts illuminate an understanding of the psychosocial needs and interventions required to address HIV/AIDS among African-Americans. Certainly primary prevention and intervention remains the most effective means of combating HIV. Social workers must be prepared to educate their clients about risk behaviors. Sexual behavior is complex. Targeted interventions, programs that address relapse prevention must be understood by social workers.

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[1]Susan Taylor-Brown, "HIV/AIDS: Direct Practice," in Encyclopedia of Social Work, 19th ed., vol. 2, eds. Jacqueline M. Atkinson and Kenneth R. Greenhal (Maryland: National Association of Social Workers, 1995), 1291-1305.

Assessment and advocacy will play a key role for social workers with this population.

According to Land, practice with HIV/AIDS population must be coupled with research.[2] Knowledge is needed about effective strategies to retain skilled social workers. It is vitally important to stay abreast of conceptual changes that result in changes in social work practice.

To gain an enhanced understanding of HIV/AIDS and social work practice with African-Americans, social workers must come to appreciate the fact that several studies have suggested differences in AIDS knowledge and attitudes related to race or ethnicity.

Equally relevant is the need to understand that through the connection between drug addiction and increased sexual activity, crack cocaine opens the door for HIV/AIDS crisis to move to the heart of the African-American community. No serious prevention can be conducted without addressing root conditions. Lynch[3] suggests that each practitioner must be AIDS-educated to provide quality services that do not perpetuate the irrational fears that are so pervasive with this disease.

Social workers have learned that information alone may not be sufficient for changing behavior or for

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[2]H. Land, AIDS: A Complete Guide to Psychosocial Intervention (Milwaukee: Family Service of America, 1992).

[3]V. Lynch, The Changing Face of AIDS: Implications for Social Work Practice (West, CT: Auburn House, 1993).

sustaining changes. Counseling methods and principles must be adapted to be congruent with client's culture, degree of acculturation, and belief systems.[4] Further research and refinement of practice skills are essential. For this to occur, social workers must develop a frame for reconceptualizing practice directed at serving hard-to-reach populations that are now poorly served or ignored.

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[4]A. Nyamathi, C. Bennet, B. Leake, C. Lewis, and J. Flaskerud, "AIDS-Related Knowledge, Perceptions, and Behaviors Among Impoverished Minority Women," American Journal of Public Health 83, no. 1 (1993): 65-71.

APPENDICES

APPENDIX A

A SURVEY ON KNOWLEDGE, SAFE SEX BEHAVIOR AND CONDOM USE AMONG AFRICAN-AMERICAN COLLEGE STUDENTS

Directions: This questionnaire is designed to study knowledge, safe sex behavior, and condom use among African-American male and female college students. Please respond to the questions below as truthfully as you can by checking the appropriate answers.

Demographics

1. Your age group:

_____ 18-24 _____ 32-38
_____ 25-31 _____ 38-44

2. Gender/Ethnicity:

_____ African American
a. _____ Male
b. _____ Female

3. Marital Status:

_____ Single
_____ Married
_____ Divorced
_____ Living with someone as if married/separated/ divorced
_____ Widowed

4. Highest Grade Completed:

College: _____ Sophomore
_____ Junior
_____ Senior
_____ 2nd year Graduate

*This survey was adapted from the "Evaluating HIV/AIDS/STD Prevention Programs on HBCU Campuses" Evaluation Manual.

5. Which best describes your current living situation:

Live in dorm	[ ]
Live in dorm shared	[ ]
Live in campus housing alone	[ ]
Live in campus housing shared	[ ]
Live in off-campus housing alone	[ ]
Live in off-campus housing shared	[ ]

Age at the time of the survey: _____

Date of Birth: _____

6. In-State Student _____ Out-of-State Student _____

HIV/AIDS Knowledge

Please check one of the following answers.

7. You can get AIDS if you have sex only once without a condom.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

8. A person can "pass" an HIV-antibody test (pass negative) but still be infected with HIV.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

9. Condoms are 100% effective in preventing HIV.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

10. Males can pass HIV on to others through their semen.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

11. You can get HIV by sitting on the seat of a toilet that a person with AIDS has used.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

12. Abstaining from sex and drugs is the best way for teenagers to avoid getting HIV.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

13. You can get HIV from drinking from the same glass or water fountain that a person with AIDS drank from.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

14. HIV can be found in vaginal fluids, semen, and blood.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

15. A person can get HIV by sharing drug needles.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

16. You can get HIV from a mosquito bite.

_____ I am sure it's true
_____ I think it's true
_____ I don't know
_____ I think it's false
_____ I am sure it's false

Sexual Behavior

17. Have you ever had sexual intercourse? ("Sexual intercourse" is defined by penile/vaginal penetration or penile/anal penetration).

_____ Yes
_____ No
_____ NA

18. How many persons have you had sexual intercourse with in your lifetime?

_____ 1
_____ 2
_____ 3-5
_____ 6-10
_____ 11-20
_____ 21-50
_____ More than 50
_____ DK
_____ NA

19. Have you had sexual intercourse in the past month?

_____ Yes
_____ No
_____ NA

20. Have you had oral intercourse in the past month?

_____ Yes
_____ No
_____ NA

21. Do you have a main or steady sexual partner?

_____ Yes
_____ No
_____ NA

(If Yes: In this question we'll call this person your "main partner." If you have more than one main partner, pick one of these partners to reference in this survey).

In the remainder of this questionnaire, when the word "sex" is used, it refers to penile/vaginal or penile/anal penetration. It doesn't include oral intercourse, heavy kissing, fondling, etc.

22. In the past month, how many sexual partners have you had?

_____ 1
_____ 2
_____ 3-5
_____ 6-10
_____ 11-20
_____ 21-50
_____ More than 50
_____ DK
_____ NA

23. In the past month, whenever you had sex, how often had you been drinking alcohol (beer, wine, etc.) before or during sex?

_____ Every time
_____ More than half of the time
_____ About half of the time
_____ Less than half of the time
_____ Never
_____ DK
_____ NA

24. In the past month, whenever you had sex, how often had you been using marijuana or other drugs before or during sex?

_____ Every time
_____ More than half of the time
_____ About half of the time
_____ Less than half of the time
_____ DK
_____ NA

Condom Use

25. The last time you had sexual intercourse with your main partner, did you use a condom (rubber)?

_____ Yes
_____ No

26. In general when you have sex with your main partner, how often do you use a condom?

_____ Never
_____ Almost never
_____ Sometimes
_____ Almost every time
_____ Every time

27. In the past month when you had sex with your main partner, how often did you use condoms?

_____ Never
_____ Almost never
_____ Sometimes
_____ Almost every time
_____ Every time

28. How long have you been using condoms (almost every time/every time) you have sex with your main partner?

_____ 1 month or less
_____ More than 1 month, but less than 3 months
_____ 3 months or more

29. In the next three months, how likely do you think it is that you will start using condoms every time you have sex with your partner?

_____ Extremely sure I will
_____ Somewhat sure I will
_____ Undecided--not sure if I could or couldn't
_____ Somewhat sure I couldn't
_____ Extremely sure I couldn't

30. This is just a "what if" question, but if you wanted to use a condom every time you have sex with your main partner, how sure are you that you could?

_____ Extremely sure I will
_____ Somewhat sure I will
_____ Undecided--not sure if I could or couldn't
_____ Somewhat sure I couldn't
_____ Extremely sure I couldn't

The following are questions about the use of condoms (rubbers) when you have sex with someone who is not necessarily a (spouse/main partner), such as someone you just met or someone you haven't been with for a while.

31. The last time you had sexual intercourse with someone like this, who's not your main partner, did you use a condom?

_____ Yes _____ No

32. In general when you have sex with someone who's not your main partner, how often do you use a condom?

_____ Never
_____ Almost never
_____ Sometimes
_____ Almost every time
_____ Every time

33. In the past month when you had sex with someone who's not your main partner how often did you use condoms?

_____ Never
_____ Almost never
_____ Sometimes
_____ Almost every time
_____ Every time

34. How long have you been using condoms (almost every time/every time) you have sex with someone who's not your partner?

_____ 1 month or less
_____ More than 1 month, but less than 3 months
_____ 3 months or more

35. In the next three months, how likely do you think it is that you will start using a condom every time you have sex with someone who is not your main partner?

_____ Extremely sure I will
_____ Somewhat sure I will
_____ Undecided--not sure if I will or won't
_____ Somewhat sure I won't
_____ Extremely sure I won't

36. This is just a "what if" question, but if you wanted to use a condom every time you have sex with someone who's not your main partner, how sure are you that you could?

_____ Extremely sure I could
_____ Somewhat sure I could
_____ Undecided--not sure if I will or won't
_____ Somewhat sure I couldn't
_____ Extremely sure I couldn't

37. The following are some things people said about condoms. As you read each statement, indicate if you agree or disagree.

		Agree	Disagree
a.	Condoms are a good conversation starter.	_____	_____
b.	Condoms are hard to put on.	_____	_____
c.	Condoms smell bad.	_____	_____
d.	Condoms are no big deal.	_____	_____
e.	Condoms prevent pregnancy.	_____	_____
f.	Condoms are not 100% safe.	_____	_____
g.	Condoms come off easily.	_____	_____
h.	Condoms break easily.	_____	_____
i.	Condoms are easy to use.	_____	_____
j.	Condoms are funny.	_____	_____
k.	Condoms prevent STD (Sexually Transmitted Diseases).	_____	_____
l.	Condoms don't feel right.	_____	_____

38. In the past month, have you talked to or asked anyone about condoms--for example, where to get them, how to use them, advantages and disadvantages, and so on?

_____ Yes _____ No

APPENDIX B

LETTERS REQUESTING PERMISSION TO CONDUCT STUDY

June 10, 1996

Professor Hattie Mitchell
Clark Atlanta University
School of Social Work
James P. Brawley at Fair Street, S.W.
Atlanta, Georgia 30314

Dear Professor Mitchell:

As part of the requirements for completing the Masters of Social Work program at Clark Atlanta University, I am required to prepare a thesis or practice based research. I have decided to complete a thesis entitled "An Exploratory Descriptive Study of the HIV/AIDS Knowledge, Sexual Behavior and Condom Use Among African-American College Students."

With your permission, I would like to interview at least thirty African-American college students. Questionnaire forms will be submitted to you for your approval.

If you have any questions regarding this study you may contact me at (404) 681-4550.

Thank you very much for your assistance and cooperation.

Sincerely,

Eva D. Robinson, MSW Student
School of Social Work

CLARK ATLANTA UNIVERSITY

June 10, 1996

Atlanta University College Students
James P. Brawley at Fair Street, S.W.
Atlanta, Georgia 30314

Dear Atlanta University College Students:

As part of the requirements for completing the Masters of Social Work program at Clark Atlanta University, I am required to prepare a thesis or practice based research. I have decided to complete a thesis entitled "An Exploratory Descriptive Study of the HIV/AIDS Knowledge, Sexual Behavior and Condom Use Among African-American College Students."

With your permission, I would like to interview at least thirty African-American college students. Questionnaire forms will be submitted to you for your approval.

If you have any questions regarding this study, please contact my thesis advisor, Professor Hattie Mitchell at (404) 880-6406.

Thank you very much for your assistance and cooperation.

Sincerely,

Eva D. Robinson, MSW Student
School of Social Work

Hattie Mitchell

Hattie Mitchell, MSW
Thesis Supervisor

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